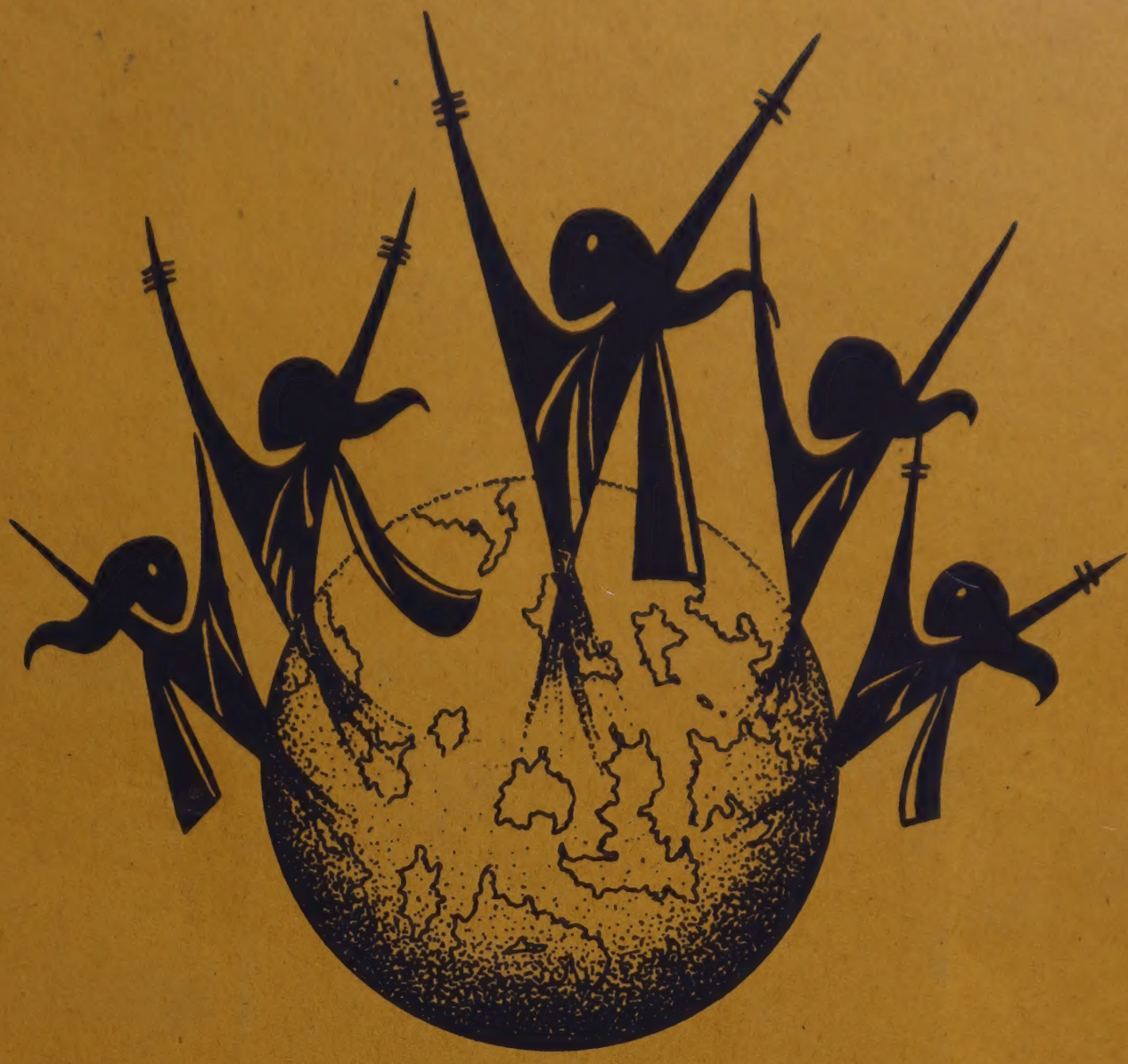

POPULATION POLICY AND REPRODUCTIVE RIGHTS

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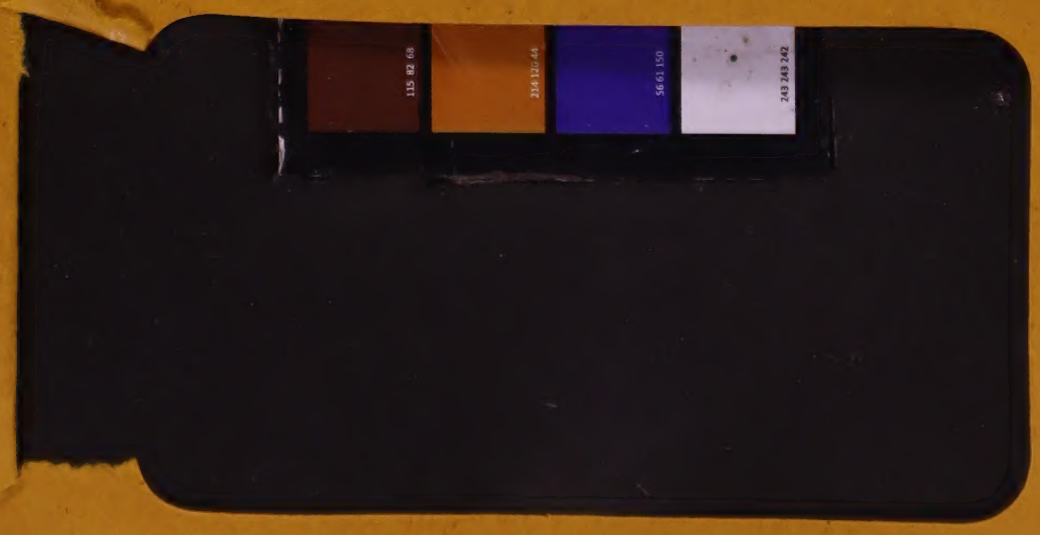

POPULATION POLICY AND REPRODUCTIVE RIGHTS

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Introduction

Population Policy and the Politics of Reproductive Rights.

I

With the UN Conference on Population and Development in 1994, the issue of population control has acquired new importance in development debates. In reviewing an old argument, the population growth in the Third world nations is being projected as a threat to economic development and as a cause for global degradation. Given such reasoning, bilateral and multilateral funding agencies are imposing population control as a major condition for developmental assistance to the Third world. Population control is also being prescribed an instrument for structural adjustment policies. The recent National Population Policy of the government of India endorses this reasoning by linking poverty and underdevelopment with population growth.

While inequity in access to economic resources and class-based exploitation are the root causes of poverty and under development, population policies and programme have sought solutions to these problems through a variety of fertility control devices. As a result, women and their reproductive rights have become the targets of population control programmes which have objectified women by reducing them to wombs whose fertility must be controlled and, if possible, rendered infertile. Thus, women are expected to carry the burden of birth control even as they are denied decision making powers, personal freedom of choice and control over their bodies.

If it is the poor and the Black women in the West who are the targets and victims of population control strategies, in India it is the poor women, who are mostly drawn from lower castes and religious minorities, have been subjected to dehumanising family planning experiments. Recently, the US courts ordered the forced implantation of Norplant on them as a punishment. In India, despite the continuous protests from women's groups, Norplant, Net-en, Depo-provera and other contraceptives are being experimented on poor women without any `informed consent'. We may also remember here that during the emergency period, women from poorer strata were coerced into sterilisation.

Such objectification of female body and sexuality and denial of freedom of choice to women on the issue of child bearing has a long history both in the West and in our own country. In this

introductory essay, I will briefly examine the history of population control movements and their ideological bases before proceeding to introduce the articles and documents which constitute this collection.

II

Population Control and Reproductive Rights in the West

The politics of population control began with the Malthusian idea of unrestrained population growth leading to impoverisation and the subsequent total destroyal of the means of subsistence. Out of this theory of population was born the 19th century movement for birth control in Europe and in North America which was led by the neo-Malthusians, the Eugenists and also by the Socialist Feminists. In the 20th century, these birth control movements coalesced into family planning and population control programmes which were forcibly imposed on the underdeveloped Third world countries by economically advanced metropoliltan nations. An analysis of these various trends and phases within the population control movement will help one understand as to what extent their policies and perspectives affected women's rights over their sexuality and bodies; and whether the family planning programmes were evolved as a means to control population growth or as to enable women to exercise control over their reproductive rights.

i) Malthus on Population and Population Control

In his "Essays on the Principle of Population", first published in 1798, Robert Thomas Malthus `demonstrated' the adverse impact of population growth on food availability and argued that "the power of the population is indefinitely greater than the power in the earth to produce subsistence for man". Drawing a simplistic parallel between population growth and food production, as if they stand unmediated by other social and economic relations, he argued that if the population growth goes unchecked, poverty will become inevitable. Hence, in his view, the poor who are the worst affected must adopt birth control as a measure to overcome problems of poverty. According to Malthus, men and women who cannot afford to raise their families must abstain from marriage as well as from "illicit" sexual relations. Further, he totally disapproved contraception which for him amounted to the encouragement of "promiscuous intercourse" and degradation of "female character". For him, intercourse without the consequence of childbirth was wrong. Following his ideas, the Malthusian League for the promotion of birth control was formed in 1877 in England

which preached birth control by means of self-control as moral restraint within marriage in order to check the so-called excessive child bearings among the poor.

What is evident in Malthusian's views on population is, first of all, his anti-poor bias. While he evaded the question of how class structure and its dynamics lead to poverty, he located the reason for poverty in the sexual mores of the poor. In other words, his argument is one blaming the victims. Equally important is the fact that, in viewing population **merely** as an issue of the economy and by treating women's sexuality as some thing which should not be freed from its patriarchal containment through contraceptives, he denied women's reproductive rights.

ii) The Eugenists and the neo-Malthusians on Birth Control

The Birth control movement in North America began with the Eugenists who, given their racism, were obsessed about racial purity and `improvement' of human race through `scientific' breeding. They advocated fertility control as a method of `perfecting' society by eliminating the growth of such sections of the population which were considered as undesirable. Through state support and legislations, they carried out sterilisation on the weak, the powerless and those belonging to so-called inferior ethnic groups. The Eugenist ideal of `racial purity' was carried out by forcing women of classes and communities which were treated as inferior not to bear children and women of classes and communities which were treated as superior to bear children. In this process of Eugenists taking control over women's wombs, they denied women their rights and control over their bodies and sexuality. Even though the Eugenics movement lost its credibility after the Nazi atrocities on the Jews and `non-Germans'/ `non-Aryan' ethnic groups, its influence is still around. It is the racist Eugenist ideas on birth control which is evident in the forcible implantation of hormonal contraceptives like Norplant on Black women with the `criminal records'in the USA.

The neo-Malthusian ideas which came to dominate the politics of birth control all over the world from 1920s for another four decades, placed importance on reproductive control as a remedy for a range of problems like poverty, retarded economic growth and degradation of environment. Dictated by utilitarian concern of class improvement, this group advocated birth control by means of contraception aiming at the fertility control of the middle class women. Later on, women of other classes too were included in the neo-Malthusian agenda. In the early 20th century, influ enced by social reform and by the radical socialist feminists, the neo-malthusians temporarily advocated birth control as

women's rights. But this was a short-lived phase. Birth control being professionalised and medicalised by 1930s, neo-Malthusians and Eugenists together began advocating family planning and "responsible Parenthood" and eliminated from their agenda women's reproductive rights. In other words, by this time, the radical feminists' advocacy of fertility control as an act of empowerment of women was totally subordinated by the economistic concept of population control.

Family Planning, Contraceptives and Demography

In the 1950s, the neo-Malthusian and Eugenist ideas of population control were consolidated with the founding of International Planned Parenthood Federation (IPPF). This organisation, which has been a major force in the population movement across the globe formulated strategies to strengthen the idea of small family instead of enabling women to realise reproductive rights.

Based on the Malthusian formulation i.e. the rapid growth of population as the cause of poverty, population policies were evolved all over the world during the 1960s and the 1970s. In the UN World population Conference of 1974, the US dictated a policy of setting demographic targets for controlling population growth. Thereby Family Planning programme were evolved and massive dissemination of contraceptives were carried out throughout world through Government and non-Government agencies. Under these programmes, economically poor women of child bearing age, who were considered `at risk reproducers', were targeted for sterilisation and insertion of contraceptives.

Early Feminists Perspectives on Population Policies

Such denial of women's reproductive rights did not, however, go unchallenged. Feminists have long reacted to policies of population and advanced alternate ways of engaging with birth control and reproductive rights. while the early feminists' efforts in recovering birth control as women's reproductive freedom were co-opted by the neo-Malthusians and the Eugenists, the later women's movement, ie., until 1980s, relegated the issue as marginal to the larger struggle against patriarchy. It may be relevant here to analyse how feminists understood and formulated the concept of reproductive right and why the earlier struggle by women for birth control could not counter the population policies of neo-Malthusian/ Eugenist which advocated fertility control.

Against the legal and religious restrictions on the practice of birth control, feminists have advocated from the mid 19th century women's right to reproductive choice as a basis for women's personal and political emancipation. In the early 20th century, the radical socialist feminists, Margaret Sanger and Emma Goldman, while demanding equal economic and political rights and equality within the family, argued for the right to birth control as vital to women's sexual and reproductive autonomy and control over their marital sexual relations. Unlike the neo-Malthusians and the Eugenists who propagated demand for birth control as a means to control population and improve the economy, radical feminists advocated birth control primarily as women's right to reproductive control. According to them, birth control symbolised reproductive self-determination of women. Hence, they insisted that motherhood should be a voluntary act and a conscious choice of women rather than being forced upon them and every woman must have the right to birth control information and services.

In order to disseminate information on birth control and make it accessible to women, Margaret Sanger founded the journal Birth Control Review in 1917 and opened a birth control clinic. In 1921 she founded the American Birth Control League and involved in its activities medical professionals and neo-Malthusians. This medicalisation of birth control and the induction of neo-Malthusian into the league marked the diminishing of feminist perspective on birth control and the beginning of dissemination of population lobby's ideas on birth control. While birth control could signify both population control and women's reproductive rights, neo-Malthusian's aggressive campaign within the league marginalised the latter meaning of birth control (i.e.Women's reproductive rights) and foregrounded the former((i.e.population control). The Early feminists, in their failure to differentially engage with each of these meanings of birth control, led to confusions in stragegy and as a consequence subverted their own radical agenda. Sanger herself compromised on the demands for birth control as women's rights and played an instrumentalist role in organising the First World Population Conference in Geneva in 1927 which was completely controlled by the Eugenists and neo-Malthusians who subverted the feminists demand for reproductive rights of women.

In India too the issue of birth control was taken up by the women's movement. Even though from 1930s the All India Women's Conference (AIWC) addresssed the issue of birth control, members of this organisation were completely polarised on the advocacy of birth control. Citing instances of maternal mortality and infant deaths, prominent leaders like Lakshmi Rajwade urged the AIWC to propagate the idea of limiting the size of the family and proposed the appointment of a committee of medical women to study

and recommend the ways and means of educating the poor women on birth control and also opening of birth control clinics. At one level, these advocates of birth control within the AIWC shared the neo-Malthusian assumptions by treating the women of poorer classes as the right to target for birth control. Simultaneously, they also moved beyond the neo-Malthusian concern by including women's health with the birth control agenda. However, unlike the European feminists, they did not ever pose the question in terms of rights of women over their sexuality and bodies.

III

The Birth Control Movement in India

The process of colonialism and the consequent exposure to western ideas brought neo-Malthusian and Eugenic ideas on population control in public debates in pre-1947 India. As early as 1920s Indian elites, particularly administrators, economists and statisticians, attempted to establish birth control clinics to disseminate information on contraception. This was a time when sexuality was not considered an appropriate topic for public discussion. In particular, women were not even allowed to articulate their opinion on sexuality in public or in mixed public groups.

The early advocates of reproductive control in India like P.K. Wattal, who wrote a neo-Malthusian tract in 1916 itself, viewed the issue of population as a reason for poverty and ill-health argued for the need to limit the same through the initiation of public policy on reproductive control. In 1921, R.D.Karve, who argued that contraception is morally acceptable, started supplying in Bombay information and appliances related to contraception. In 1924, N.S. Phadke established the Bombay Birth Control League to propagate the idea of reproductive control. In 1927, in Sholapur, a Eugenics society was formed to prevent the "multiplication of the inferior" through birth control methods, and advocated measures like opening of Mothers Clinics. As early as 1880s, the neo-Malthusian league was formed in Madras. After a period of inaction, it was revived by elite Tamil Brahmins who firmly believed in racial improvement. They propagated Eugenic ideas on reproductive control through Madras Birth Control Bulletin and sold various contraceptives.

These associations which propagated the Eugenic ideas of improving Indian Population through reproductive control were the catalysts for shifting the birth control agenda from women's health issues to Family Planning. Significantly, none of these

organisations included women in planning and decision makings of birth control initiatives. Men in this forum even dismissed women's knowledge of birth control. When Margaret Sanger wanted to involve Indian women in birth control debates, Indian men insisted that only they were qualified to discuss the issues of birth control and not women.

Thus the early birth controllers, who had drawn their ideas from the Eugenists and the neo-Malthusians, associated birth control with the population control, and did not address issues of women's health and reproductive rights. Their opposition to women's reproductive rights was evident in their opposition to women activists who were willing to participate in the birth control movement on account of women's health.

The nationalists, on the other hand, under the influence of Gandhi, vehemently opposed birth control on the ground that it would lead to sexual promiscuity and dissolution of marriage. Gandhi considered sexual union as proper only when it was meant for procreation. While, due to religious and social conservatism, many congress leaders avoided discussions on reproductive control, Hindu conservatives used religious rationales to oppose birth control. They claimed that the nature of women's body demanded that she must deliver a child every three years. In reducing women's sexuality exclusively to child-bearing and presenting child-bearing as the duty of women, both the Gandhians and the Hindu conservatives subverted women's rights over their bodies and sexuality.

On the other hand, Muthulakshmi Reddy and others within the AIWC opposed birth control and proposed a comprehensive approach to improve women's health through the opening of maternity and child welfare centres to educate men and women about health needs. As far as birth control was concerned, the maximum they could accept was Gandhian self-control which in fact, as we have seen, reinforced the culturally constituted link between sexuality and fertility and refused women reproductive rights.

Birth Control in Post-1947 India

Strong opposition from Hindu conservatives and the nationalists, along with the immediate concerns of independence, had prevented any debates on reproductive control through contraception until 1940s. But by 1949, the Eugenic and neo-Malthusian concerns of birth control were revived in the form of Family Planning Committee which cleverly co-opted women like Lady Rama Rao

who became the president of the committee. With financial assistance provided by international agencies such as Rockefeller Foundation, this committee was involved in designing the earliest population policy in this country. By 1951, this committee was consolidated under the name of Family Planning Association of India (FPAI) which undertook the task of carrying out the population control programme. In the same period with the same objectives the International Planned parenthood Federation (IPPF) was founded in Bombay by Margaret Sanger and Lady Rama Rao.

The Family Planning Programme and Women's Health

In the 1960s the myth of `population explosion' propagated by the developed metropolitan countries and the consequent promotion of family planning strategies by the international funding agencies under the guidance of the USAID, motivated the Indian state to advocate family planning programme to the exclusion of most other health services. As well known, India was one of the earliest proponents and advocates of family planning through fertility control methods. Mass education (more as propaganda) on the need to limit the family size and incentives for couples who utilised contraceptives were some of the strategies evolved to promote family planning programmes. However, these strategies failed miserably without meeting the specified target of birth control. As a result, with the advice and specific recommendation of aid agencies, the state integrated the Family Planning Programme with Maternal Child Health (MCH) in order to target women of child bearing age.

By 1970s the MCH programme became a family limiting service distributing pills and other contraceptives for women in the name of reducing maternal mortality due to child birth. We may note here that contrary to the belief that contraceptives prevented increase in maternal morbidity it was the weaker public health services which contributed to increase in maternal mortality and infant death. Since resources allocated to other health services were appropriated for the Family Planning, maternal mortality increased due to anemia which could not be tackled merely at the time of pregnancy. In other words, the fact of the matter is the government was not bothered about women's health, not to speak of women's reproductive rights, while it talked of birth control.

It was around the same time, the frenzy to meet targets of family planning led the state to recruit the armed forces, paramilitary forces, NCC, NSS to carry out Family Planning programme. While forced sterilisation were carried out on men, the inject-

able family limitation techniques were imposed on women. The imposition of injectable contraceptives like, Net-en, Norplant, depo-provera, anti-fertility vaccines on women have completely taken away women's control over their bodies. For instance, the hormonal contraceptives like Norplant, once injected into woman's body, remain there for five years when her fertility is under control. Thus this technology becomes a tool in the hands of the state to control and usurp women's right and control over their bodies. If the black women are the victims of Norplant in the USA, in India the Norplant trials are carried out on women of lower classes, castes and minorities. In fact, it is by now well known that all the 20,000 women who were under Norplant trials in this country were ignorant about the effect of injectable contraceptives.

All these experiments with women's bodies by the state and its agencies show how the population policies and development programmes have placed the population control as their central agenda and denied women their reproductive freedom and control over their life situations.

It was the introduction of these new contraceptives that brought women's organisations and progressive health groups together world-wide to question the ethics of promoting these contraceptives and to challenge the medical establishments for carrying out trials on Third World women. As a result of their struggles, new reproductive health strategies are slowly emerging.

IV

Feminist Perspectives on Reproductive Health

The population policies and programme, particularly the imposition of various contraceptive devices on women which has affected women's health and reproductive rights, are increasingly making women aware of their health needs and reproductive rights. In recent years, this awareness has led them to mobilise women's opinions and articulate their needs through women's movement. They also closely scrutinise the population policies from the point of view of whether they contribute to an increased decision-making power for women and also whether these policies help women move towards transforming unequal gender relations. Apart

from critiquing the sex-biased population policies they also demand that women should be participants in planning and executing policies that affect women.

The perspective that every woman has the right to control her own sexuality and reproduction without discrimination as to age, marital status, income, caste, class, religion and other consideration has led to the evolution of reproductive health approach. An approach which addresses the issue of women's health in general and reproductive health in particular but not fertility control.

This reproductive health approach is premised on the following objectives:

i) evolving a comprehensive socio-economic, legal and biomedical framework for reproductive health;

ii) empowering and conscientising women to understand their reproductive health requirements;

iii) ensuring public dialogue and creating public awareness about reproductive rights and population issues;

iv) Supporting community based activities on the issue of women's reproductive health;

v) developing and encouraging women centred models for reproductive health care and supporting education on these rights.

iv) promoting dialogue and networking among women's groups on health related issues.

Linking up reproductive health with reproductive rights of women, feminists have suggested the following alternatives and strategies for an effective population policy.

i) Transforming the prevailing relations of authority and subordinations between men and women across different levels of society such as family, caste and religion.

ii) Empowerment of women as central to population policy proposals and implementation. i.e. perceiving women as active subjects and agents and not as passive recipients of social change.

iii) Empowering women to excercise reproductive con-

elimination of all forms of discrimination against girls and women; c) must undermine pro-natalist patriarchal relations in the family, community, and nation. In this context, the development policy of which population policy is one component must become a human rights policy ensuring substantial standard of living and other basic freedoms. Only within this framework the family planning programmes, devoid of demographic drive, can ensure high quality sexual and reproductive health services through reproductive rights policy.

Population Policy and Development: A critique

The second section in this collection contains articles critiquing the existing population policy and the development programmes from feminist perspectives. The first paper in this collection on "Rethinking Population Policy", while contending that the development process do not entirely depend on population control, effectively argues that the problems of underdevelopment and poverty are not related to population growth but to various factors like inequity, overconsumption of resources by the developed nations and massive spending for strengthening state machineries like military expenditure etc. By overlooking these factors, the government has got obsessed with the strategy of family planning. The author points out that despite the increase in the national expenditure on Family Planning Programme (which went up to 24.7% of the overall health budget), the programme became a total failure because of its single priority of fertility control. The entire health service was geared towards achieving the targets at the cost of public health services and women's health.

In analysing the state's policies on population control and its development perspectives from the point of their effect on women, the second paper too argues that the fertility control do not lead to improvement in women's health. Based on her survey of women from two poor communities in Tamilnadu, the author contends that the top-down approach of the Family Planning Programme have not integrated the reproductive health care within its scope. Thus, women are treated as passive recipients of the programme which has marginalised women's requirements and priorities. Suggesting an alternate policy, she argues that the population control programme must be accompanied by women-centered economic and social transformation including redistribution of land and other means of production, free and equal access to education and suitable rural development policies to generate sufficient employment and other facilities. Further, for her, women's requirements and interest must dictate programme priorities and strategies rather than demographic calculations.

trol by making decisions not only about conttraception, but also about other sexual and reproductive health needs and about sexuality itself.

V

Now let us turn to the collection of articles, reports and documents that are put together here which analyse and critically reflect on development strategies and population control programme. For the convenience of the readers, we have classified the collection into three sections.

The first section of this collection contains two articles which deal with theoretical perspectives on population control and the feminist struggle for reproductive rights. These articles have already appeared in a book written by Ruth Dixon-Muller, **Population Policy and Women's Rights: transforming Reproductive Choice.**

In the first article, she traces the history of population control debates and population control movement in Europe and the feminists struggle for redefinition of birth control from the point of view of women's rights over their bodies and freedom of choice and information. Her contention is that the earliest advocacy of birth control and population control was inherently anti-women since they eliminated the issues of women's health and reproductive rights from their debates and policies. In contrast, the socialist feminist's advocacy of birth control emphasised these rights as important agenda for the women's participation in reproductive control. However, this radical position of the early feminists were co-opted by the neo-Malthusians. She further argues that in the absence of concrete social, political and economic reforms, population policies were promoted only at the cost of women's interest.

In the second article, "Women's Rights and Reproductive Health: A Policy Agenda", she defines as to what should be the alternative reproductive policy. In proposing a reproductive rights policy as an alternative to family planning policy, she argues that fertility control must result only from the transformation of material and social conditions which would empower women to exercise control over their own sexual and reproductive capacities. While pointing out the problems with the existing population policies, she elaborates the need for a population policy as equal rights policy which would, a) promote women's economic, social, political and civil rights; b) work towards the

The third article in this section specifically analyses the recent Draft National Policy and its implications for women and other oppressed groups. It points out how the draft policy has failed to evolve an integrated approach to development/human right issues and questions the ethics of the policy document as it fails to address issues which affect people's lives such as growing economic and social inequity, problems of malnutrition, hunger, poverty, unemployment, unequal land distribution and uneven industrial development. It also argues that the draft's attempt to evoke gender equality remains merely as a rhetoric as it fails to account for the growing feminisation of poverty, violence against women in the family, women's lack of independent sources of income and decision making power.

The Struggle for Reproductive Rights:

The third section and the last in this collection includes reports of conference and other documents. They include,

a) reflections on the experiences of using contraceptives like Norplant, shared by women who have undergone these trials - put together by the Forum for Women's Health (FASDSP).

b) proceedings of the International Women's Health Conference held in Rio de Janeiro in 1994 and the proceedings of Reproductive Health Meet held in India.

c) women's group's perspectives on women's health in the Medico Friend Circle Annual Meet on Reproductive health held in January 1994; and a draft statement on population policy from women's perspective contributed by one of the member of the expert group on population policy appointed by the Government of India to draft the new policy perspective.

These documents and reports will be of relevance to understand the ongoing women's struggle to define reproductive health and evolve strategies to counter authoritarian population control programmes.

ANANDHI. S.

SECTION I

2

"POPULATION CONTROLLERS" AND THE FEMINIST CRITIQUE

Feminism, women's rights, birth control, population control: they are all social movements engaged in political action to promote specific policy agendas. Connected in complex and sometimes combative ways with one another, they are also involved in collaborative or antagonistic relationships with other social/political movements: with liberalism, radicalism, and socialism, for example, and with ethnic and state nationalism and religious fundamentalism. The ideas of these and other movements compete in a clash of contradictory ideologies backed by interest groups with varying degrees of power. Competing claims often incorporate the control of women's bodies and women's lives as symbols of group power. In the midst of antinatalist and pronatalist agendas, feminists claim the right to control their own bodies and their own lives.

The three chapters of this section analyze the politics of the women's movement and the birth control/population control movements from different vantage points. This opening chapter tells the story of feminist reactions to the campaigns for birth control in Europe and North America in the latter part of the nineteenth century and for population control in the latter part of the twentieth. It examines the roots of the contradiction between early liberal-reformist feminism and the birth control movement that raise questions of relevance today. Are artificial methods of contraception truly liberating for women or do they simply make it easy for men to have unlimited sexual access without having to engage in "cooperative self-denial" (for example, by practicing coitus interruptus or periodic abstinence to avoid unwanted pregnancy)? The early feminists were pas-

sionately committed to the idea of "voluntary motherhood," but on their own terms. It was not until the beginning of the twentieth century, with the rise of socialist agitation and radical feminism, that birth control was defined by activists such as Margaret Sanger and Emma Goldman as vital to the class struggle and to women's sexual liberation. The first clinics opened their doors in a spirit of open defiance of legal and social conventions. The subsequent evolution of the family planning "establishment" took quite another turn, however. Increasingly professionalized, medicalized, and respectable, it lost its feminist fervor in the decades following the 1920s. "Responsible parenthood," not women's liberation, was the primary goal.

The renewal of feminist activism in the late 1960s in the United States involved, among many other issues, a protracted struggle for the recognition of reproductive rights and the legalization of abortion. But feminist health advocates have been increasingly critical of many of the developments in family planning programming and contraceptive development. The growth of a powerful movement for population control has attracted strong opposition. Although feminists insist that every woman has a right to birth control information and services, they have challenged population control policies and programs because the latter's political agendas seemed to exclude a fundamental concern with empowering women. "The major difference . . . between the feminist agenda and most population agencies is that feminists see the use of family planning within the context of sexual power dynamics that subordinate women, and *they place the highest priority on helping women change these dynamics*" (Helzner and Shepard 1990, p. 153; emphasis added). Programs that do not recognize these priorities do women a disservice, feminists contend, by perpetuating male power and privilege.

The perspective of the population establishment is addressed in chapter 3, which tells a story about the shifting position of the United States government on population and family planning at home and abroad. The government's position evolved from a tentative interest in supporting family planning research and programs in the 1950s, to enthusiastic endorsement of international population control efforts in the 1960s and 1970s, to revisionism in the 1980s when U.S. policy fell under the sway of conservative economic ideologies and organized attacks on family planning by fundamentalist religious groups. Because most policymakers revealed little awareness of (or interest in) the implications of their policies for women's lives, the "woman question" remained peripheral to most of the domestic and international policy debates. Planners and researchers were more interested in macro-level analyses of the effects of population growth on economic development, environmental deterioriation, food supplies, and political security. These were the "hard" questions. Except for some expressed concern with women's and children's health and fam-

ily welfare, the "soft" questions remained largely unexamined. Advocates of women's rights along with other critics of the ethics and practices of the population controllers were alienated from the policy process. Only recently have they mobilized around the issues of improving the quality of care in family planning programs and protecting women's health and rights in domestic and international programs.

The dilemma of women's health advocates in developing countries who are caught between the ideologies of population controllers (generally reflecting U.S. policy) and of nationalist and religious pronatalist movements is described in chapter 4. Womens' organizations in Brazil, Nigeria, and the Philippines have tried in various ways, some successful and some not, to influence or challenge the population policies of their countries as democratization in the 1980s has opened up new avenues of political engagement. The possibilities of extending comprehensive reproductive health services to women as a basic entitlement have been tempered by the harsh realities of economic austerity as well as by political resistance from conservative sources. Feminists in these and other southern countries are struggling to identify key issues and programs that will reflect their *own* sense of priorities rather than those of national political parties and elites, powerful religious institutions, and the international population establishment. They are also developing a unique feminist identity which, on some political issues, sets them apart from or even in opposition to many feminists in the north. Histories of colonialism, imperialism, racism, and economic exploitation that have produced glaring international disparities in power, privilege, and wealth are far too powerful to be ignored. A major challenge to the global women's movement is to transcend these geopolitical divides in the defense of women's reproductive health and rights.

The women's movement in both northern and southern countries has been caught in a double bind on the birth control question, largely because the feminist concept of fertility control as an individual, autonomous act of empowerment has been eclipsed by the political concept of population control as a public policy imposed by governmental authorities or other ruling elites. The feminist response has been a sharp and vocal critique of "controlista" ideologies and practices launched from outside the major population institutions, a persistent attempt at reform by feminists (both male and female) from within, and an unanticipated and potentially devastating co-optation of feminist criticisms by anti-feminist, "right-to-life" organizations.

The feminist critique has shaped the dynamics of the relationship between women's groups and the population/family planning establishment in fundamental ways. Unfortunately, it has also contributed to a situation in which groups that in principle should be natural allies in the defense of reproductive rights often work at cross purposes in an atmosphere of

mutual distrust. Some radical feminist groups attack virtually all new contraceptive technology on political grounds without engaging in the kind of scientific fact-finding that might make their arguments more persuasive and their conclusions more nuanced. Some insist that virtually all family planning programs are imperialist or racist by definition and thus should be rejected. In short, they are too prone to throw out the baby with the bathwater. At the same time, population planners and contraceptive researchers tend to dismiss feminist complaints as uninformed, emotional, and representing a minority view. Preoccupied with achieving their own political and scientific goals, they fail to take seriously the legitimate concerns that feminists raise about women's health and rights. The contradictions embedded in these issues, which have divided the women's movement from the birth control/population movements and the women's movement within itself, can be traced to the first organized campaign for birth control in England over a century ago.

THE ROOTS OF CONTRADICTION: FEMINISTS AND NEO-MALTHUSIANS IN THE NINETEENTH CENTURY

The deep ambivalence of many contemporary feminists about the promotion of artificial methods of contraception has its roots in the reactions of first-wave feminists to the rise of the neo-Malthusian birth control movement in England in the latter part of the nineteenth century.

Birth rates were falling throughout the nineteenth century in England and in some northern and western European countries, beginning earliest in France (and the United States). Delayed marriage, nonmarriage, and the practice of coitus interruptus within marriage were primarily responsible. By the late nineteenth century, birth control information and technology, originally the preserve of the propertied middle classes, permeated the "popular" or working classes (Fryer 1965; Shorter 1973). In Germany, for example, entrepreneurs were producing rubber and chemical products such as condoms, diaphragms, douches, and vaginal suppositories advertised "for the Malthusian," while professional and indigenous healthcare practitioners offered abortion and sterilization services (Woycke 1988:4). Pharmacies in England displayed a variety of contraceptive wares. The sensational trial of birth control crusaders Annie Besant and Charles Bradlaugh in 1877 on charges of obscenity for publishing a book on contraception (Charles Knowlton's *Fruits of Philosophy*, first published in the United States in 1832) had sparked enormous interest in birth control among the general public. A Dutch physician opened the first office to dispense contraceptives (primarily the diaphragm) to women in 1882. At the same time, the ideology of female emancipation was politicizing women in England and throughout Europe among the bourgeoisie and the intellectual classes. The rise of a European liberal-reformist fem-

inist movement protesting women's unequal opportunities was reflected in the rapid growth of local, national, and international women's associations concerned with female suffrage and other aspects of women's social, economic, and political rights (Riemer and Fout 1980:59–62).

Based largely on the theories of Thomas Malthus in the multiple versions of his *Essays on the Principle of Population* (first published in 1798), the Malthusian League for the promotion of birth control was started in England in 1877. Meetings of neo-Malthusians were held throughout Europe in the 1880s and 1890s. Organizations were formed in Holland, Germany, and France, and an International Neo-Malthusian Federation started in 1900 (Pierpoint 1922; Glass 1940). Attracting a variety of freethinkers, liberal reformers, and utopians, the movement adopted Malthusian economic arguments but departed from Malthus's own views in crusading for the adoption of birth control *within* marriage. Malthus had preached "moral restraint" rather than contraception as the check against excessive childbearing among the poor. Men and women were to abstain from marriage and from illicit sexual relations until they could properly afford through their hard work and frugality to marry and raise a family. In no case was "promiscuous intercourse" to be countenanced, by which Malthus meant "that which employed improper arts" to prevent the birth of children, because it would "weaken the best affections of the heart, and in a very marked manner . . . degrade the female character" (Malthus [1817] 1963:266). In contrast, the neo-Malthusians promoted birth control both for its economic advantages and as a means of avoiding "the evils of abstinence" for men or their resort to prostitution (Banks and Banks 1964:118).

Neo-Malthusian propaganda aroused a storm of protest from some quarters, especially as expounded by the Malthusian League and its precursors in their "crusade against poverty" (Fryer 1965:89–189). The British labor movement challenged the League's economic argument that surplus labor was the root cause of low wages and poverty. Public figures in the medical profession claimed artificial contraception to be unnatural and unhealthy. The greatest resistance came from religious moralists who believed that birth control would encourage licentiousness both within and outside marriage by making possible the enjoyment of sexual pleasure while preventing procreation (Banks and Banks 1964:120). In this sense the moralists shared Malthus's view that intercourse without the consequence of childbirth was wrong.

Ironically, bourgeois Victorian feminists appear to have acquiesced in the moralists' view, although from a different perspective. According to historians J. A. and Olive Banks (1964), "Far from believing family limitation by means of contraception to be a further step towards their emancipation, they appear to have seen it as yet another instance of their *subordination to man's sexual desires*" (emphasis added). Expressed in

this way, their reactions have a certain radical bent. It was not that British feminists were oblivious to the problems of excessive childbearing; far from it. Nor were they oblivious to the advantages that female-controlled contraceptive methods such as douching, vaginal suppositories, cervical caps, or vaginal sponges might bring in comparison with male-controlled methods such as condoms or withdrawal (coitus interruptus). Indeed, a number of them undoubtedly used such methods themselves. But, in their public stance, feminists were concerned that artificial contraception would weaken whatever control women may have gained over their own persons by undermining their ability to regulate sexual access on the grounds of avoiding unwanted pregnancy. Women also feared that contraception would encourage philandering on the part of their husbands, who could take other women at will without fear of pregnancy. Sexual and reproductive autonomy were closely linked in this view: a woman's control over childbearing would be achieved primarily through her control over marital sexual relations. A husband should respect his wife's wishes by practicing withdrawal or abstinence—that is, through *cooperative self-denial*.

The theme of sexual autonomy—of women achieving control over the couple's sexual relations—also appears among early liberal feminists in the United States. The Grimké sisters, Elizabeth Cady Stanton, Charlotte Perkins Gilman, and Elizabeth Blackwell all attested to the healthy nature of women's sexuality. Indeed, women's sex drives could equal or exceed men's, they noted, were it not for the pervasive social efforts to suppress it and for the "ignorance and selfishness of men in the sexual act" (Degler 1980:265–268). Nevertheless, in uneasy partnership with social purists who preached against excessive sexual indulgence, early American feminists also advocated sexual limitation within marriage as a means of granting women greater sexual autonomy. Elizabeth Cady Stanton, for example, asserted in 1853 that "Man in his lust has regulated long enough this whole question of sexual intercourse." One of the Grimké sisters insisted on woman's right "to decide when she shall become a mother, how often, and under what circumstances" (ibid.:272). In other words, feminists argued for a wife's unilateral right to refuse her husband's sexual demands. This was a revolutionary concept at a time when a wife was considered the private property of her husband in law and practice.

The hopes of reformers that husbands would cooperate in a regimen of self-imposed or female-controlled periodic celibacy appear to us now as idealized and fundamentally class-based. Even upper middle-class women lacked access to potentially empowering resources beyond those of moral persuasion. Working class women struggling to survive economically could not possibly have identified with (or been mobilized by) the principle of "sexual limitation." Nevertheless, the concept of women having ultimate control over their sexual and reproductive capacity—that is, the

principle of voluntary motherhood—was a powerful component of the early feminist agenda for female emancipation and women's rights (Gordon 1976). Women would gain this control either within marriage or, at the extremes, by rejecting marriage altogether through singlehood or divorce.

Nineteenth-century bourgeois feminists remained suspicious of those advocates of artificial contraception who, it seemed, were men concerned primarily with their own sexual pleasures. Feminism was not a causal factor in the advent of family planning in Victorian England (Banks and Banks 1964:129). Rather, it was the neo-Malthusian crusade combined with socioeconomic changes, especially in the middle classes, that appeared to be primarily responsible for the spreading practice of family limitation in that country (Banks 1954). In the United States, the birth control movement was fueled in the first half of the twentieth century by liberal lay persons (both women and men) concerned with issues of family health and welfare who increasingly won the medical professionals over to their cause (Fryer 1965:215). There was little feminist activism within the movement, with the notable exceptions of Emma Goldman and Margaret Sanger.

BIRTH CONTROL AND SOCIALIST/RADICAL FEMINISM IN THE EARLY TWENTIETH CENTURY

The movement for socialist feminism which arose in Europe and North America in the latter part of the nineteenth century and flourished in the first two decades of the twentieth century was inspired in part by August Bebel's feminist tract, *Women Under Socialism*. Published in 1879, the book went through 55 editions by 1930 and was translated into 20 languages (Winter 1989:123). Socialist feminists were demanding the same economic and political rights as men and equality within the family, which included the right to divorce and to limit the number of births (Quataert 1979; Riemer and Fout 1980).

The demand for birth control divided the socialist movement, however, particularly in Europe where many socialists adhered to an orthodox line (Petersen 1989; Winter 1989). Some birth control opponents spoke from a position of ideological purity: family limitation was reformist, they argued; moreover, it sacrificed the collective and revolutionary interests of the working classes to the personal interests of the individual. Excessive individualism was causing dangerous declines in birth rates which threatened the future of socialism. Other opponents disassociated themselves from the economic theories and reformist politics of the neo-Malthusians and from the anarchists, whose advocacy of birth control—rooted in hostility to the state and the bourgeois family—carried a strong (and not at all respectable) element of sexual liberation. Still other socialist critics

spoke against the movement from a position of compromise. With a relatively small base of electoral support in most European countries, they contended, socialist parties should build coalitions with middle-class constituencies by emphasizing family and nation-building as common values (Winter 1989:134).

The idea of separating sex from reproduction was becoming generally accepted in the United States by the second decade of the twentieth century. Women, especially working-class women, were entering the labor force in large numbers. The birth control movement that began in the United States in 1914 was, according to historian Linda Gordon (1976:207), " . . . part of a general explosion of resistance to economic and social exploitation." Its radical proponents (both socialist and anarchist) argued that birth control was not an incrementalist reform but a revolutionary change that would transform society toward free sexual expression, reproductive self-determination, and human rights.

Self-proclaimed freethinkers and "militant feminists" Emma Goldman and Margaret Sanger, both of whom published pamphlets on contraceptive techniques among their many other writings and speeches, crusaded for birth control as a means of opposing male tyranny and liberating female sexuality (a radical feminist position). Their crusade had a socialist and pacifist justification as well: birth control among the poor and working classes would serve as a weapon in the class struggle against capitalist exploitation, which relied on a reserve army of workers to keep wages down, and against militarism, which relied on mass mobilization (Gordon 1976:212–219; Kennedy 1970:127–135; Fryer 1965:201–219).

In Goldman's view, birth control was "the most dominant issue of modern times" which "cannot be driven back by persecution, imprisonment or a conspiracy of silence" (Goldman 1916:471). The federal Comstock law, which was passed in 1873 and not repealed until 1971, forbade the importation or distribution through the mails of so-called obscene materials such as birth control information or supplies. In 1914 Sanger launched a short-lived monthly publication called *The Woman Rebel* which had two purposes: first, to test the Comstock law; second, "to rally friends and supporters to the cause of militant feminism in general, contraception in particular" (Fryer 1965:204). The first issue included an extract from Goldman's essay on love and marriage urging women not to have children if they did not want to. Sanger, in turn, asserted women's right to have children without being married, as well as their firm duty "to look the whole world in the face with a go-to-hell look in the eyes; to have an ideal; to speak and act in defiance of convention" (ibid.). The expression "birth control" was printed for the first time in the fourth issue of *The Woman Rebel* in June 1914 (Fryer 1965:205). Sanger and her friends had searched for a name that would convey the "social and personal significance" of the movement. Having rejected a number of alter-

natives, they finally agreed on birth control as the perfect name for the cause.

In 1914 Sanger also published the first edition of *Family Limitation*, a widely distributed birth control pamphlet that ran eventually to ten editions. *Family Limitation* described in graphic terms how a woman could prevent pregnancy with douches, condoms, pessaries, sponges, and vaginal suppositories, while condemning the use of coitus interruptus because it was unreliable and could have a "degrading" and "injurious" effect on women (Jensen 1981:559). The journal *Birth Control Review* inaugurated by Sanger in 1917 continued publication until 1940.

Despite anti-obscenity laws and harassment from moralists, in 1916 Margaret Sanger opened the first birth control clinic in the United States in an impoverished working class neighborhood of Brooklyn. With several colleagues she distributed leaflets printed in Yiddish, Italian, and English throughout the neighborhood. Hundreds of women showed up for services the first day. The movement spread: women in other locations quickly followed by opening clinics (usually for fitting vaginal diaphragms) in defiance of the law. The resulting arrests and trials brought much publicity and support for the cause. The first public centers for family planning service delivery in the United States were thus created in the spirit of a strong feminist ideology as a direct challenge to oppressive legal and social institutions that denied women their rights to reproductive self-determination. Birth control formed the basis of a large and radical movement involving not only educated but also working-class women in participatory and defiant social action (Gordon 1976:229).

Similiar events followed in England a few years later. In a working class community in 1921, feminist author Marie Stopes and birth control crusader Humphrey Verdon Roe opened what they claimed was the first contraceptive clinic in the British Empire (Fryer 1965:228). Like Sanger, Stopes was also subjected to years of legal harassment as well as to attack by the medical profession, church representatives, and other defenders of public morality. The Malthusian League opened its first clinic a few months later. The number of clinics grew rapidly in Britain following these beginnings, primarily under the aegis of the Society for the Provision of Birth Control Clinics formed in 1924. By the late 1920s at least 300 birth control centers were to be found in Great Britain, Germany, Austria, and the United States (Robinson 1930). In the Soviet Union, a law was passed in 1920 under the administration of feminist Alexandra Kollontay, Commissariat of Public Health, entitling any woman with less than three months' pregnancy to procure an abortion from a qualified physician, and to rest and care after the operation at the expense of the state. Leftist feminists in Czechoslovakia, Germany, Austria, and Great Britain, were agitating for similar rights (Pierpoint 1922:42).

The influence of these early feminist crusaders was to be felt in many

parts of the world, not only in North America and Europe but in southern countries as well. In Yucatán in Southeast Mexico, for example, Sanger's book *Family Limitation* was published and disseminated widely following the first Feminist Congress held there in 1916 which was chaired by the governor of the state. In 1925, during a strongly anti-clerical political regime, the book was distributed freely throughout Mexico (Cabrera 1990). In 1922, Margaret Sanger reported to the Fifth International Neo-Malthusian and Birth Control Conference held in London on her triumphal tour of Japan, China, and Korea. Sanger's American Birth Control League had affiliates in Mexico, Hawaii, Japan, and China, and an Indian Birth Control Society had been started under her influence.

The 1920s marked a turning point in the birth control movement. The Report of the Fifth International Neo-Malthusian and Birth Control Conference in 1922 had a crusading ring to it, but the movement was determined to appear respectable in its promotion of "decency and sexual purity;" in its economic and medical justifications for birth control; and, increasingly, in its eugenic arguments on the scientific improvement of the human race (Pierpoint 1922). The voice of women's liberation was dimming. Speaking as a member of "a very small minority" in the movement, British feminist and communist Stella Browne told the audience that "In my opinion . . . the fundamental importance and value of Birth Control lies in its widening the scope of human freedom and choice, its *self-determining* significance for women. For make no mistake about this: Birth Control . . . means freedom for women, social and sexual freedom, and that is why it is so intensely feared and disliked in many influential quarters today" (ibid.:40; emphasis in the original). Wondering aloud why scientists could not invent better contraceptive methods that would "prevent conception without injuring health or impairing natural pleasure," Browne announced in conclusion her profound conviction that abortion is a "woman's primary right" (ibid.:42).

PROFESSIONALIZING PLANNED PARENTHOOD

As socialist and feminist agitation faded following the First World War, the birth control movement in the United States became increasingly professionalized, institutionalized, and national in scale (Gordon 1976: 249–300; Piotrow 1973:7–19). As early as 1915, a variety of birth control leagues had been organized by middle-class, reformist women (Hodgson 1991:15). Although some socialist women remained committed to the cause, many abandoned and some attacked the fight for women's sexual and reproductive rights after 1920 to focus on union organizing, a class-based action considered less divisive to the socialist cause. Meanwhile, sharing with other political groups a widespread concern over declining birth rates and prospects of impending "depopulation" in Europe (es-

pecially in France, Belgium, and Germany), European socialists were favoring pronatalist family protection policies over women's rights and the fight for birth control (Winter 1989).

The evolution of Margaret Sanger's career embodies the transformation of the birth control movement from its feminist and radical phase to one of social reformism and medical respectability. In the 1920s and even later, many physicians were still publicly opposed to contraception, which, with the exception of periodic abstinence (taught incorrectly in ignorance of the true fertile period), most believed to be injurious. Physicians were also worried about the association between contraception and adultery, premarital sex, radical feminism, and medical quackery (Hodgson 1991:14). By the 1930s birth control was becoming a legitimate medical issue under Sanger's leadership. It was not until 1937, however, that Sanger's efforts to win over the medical establishment resulted in the American Medical Association's endorsement of contraception as a therapeutic health measure (Kennedy 1970:172–217). Even then, many physicians in the United States as well as in England and Canada hoped to disassociate themselves from a movement influenced by lay persons (e.g., Sanger herself) and from a subject they considered "distasteful" (Field 1983:226–230).

From the 1920s on, Margaret Sanger directed her attentions not only to winning medical respectability for birth control within the United States but also, increasingly, to winning scientific and political support internationally. Her efforts began in earnest in 1922 with her highly publicized visits to China, Korea, and Japan. A world conference which she organized in New York in 1925 resulted in the formation of the International Federation of Birth Control Leagues (ibid.:219). In 1927 she organized the first World Population Conference in Geneva. Sanger's sponsorship apparently caused the assembled scientists some discomfort, however: not only did they refuse to acknowledge her role officially, but they also barred the topic of contraception from the agenda (Piotrow 1973:8). Meeting privately in Paris the following year, the scientists organized the International Union for the Scientific Study of Population (IUSSP). At a 1948 conference, Sanger helped to form the International Committee on Planned Parenthood which in 1952 became the International Planned Parenthood Federation (IPPF) with Sanger and Lady Rama Rao of India as joint honorary presidents. Although the scientific community was never at ease with her activism, Sanger had muted much of her early feminism and grass-roots orientation in her quest for scientific acceptance of the cause.

The American movement's change of name from Birth Control to Planned Parenthood was symbolic. The movement would now enable married couples to "plan their families." The concepts "planned parenthood" and "family planning" reflected an ideological shift toward

strengthening the family as a unit rather than *freeing women*, married or unmarried, to accept or reject sexual relationships and motherhood on their own terms. In 1938, rival organizations such as the American Birth Control League (Sanger's organization) and the Voluntary Parenthood League joined to form the Birth Control Federation of America, which in 1942 changed its name to the Planned Parenthood Federation of America (PPFA) in order to shed the "negative" image of birth control (Gordon 1976:341). Planned parenthood represented the triumph of experts—of scientists, physicians, economists, statisticians—over grass roots activists, not only obliterating the movement's radical and feminist flavor but also attracting eugenicists who were specifically anti-feminist in their fears of family breakdown and race suicide.

The eugenics attraction was not new. The possibilities of selective birth control had drawn believers in racial improvement from the start, both in Europe and North America. Writers in the United States in the 1890s spread fears of "racial degeneration" from the profligate breeding of the genetically unfit, including the Southern European "races" (Hodgson 1991). The movement gained momentum with the passage of discriminatory immigration laws setting national origins quotas in the early 1920s. Proponents advocated both "positive" and "negative" eugenics: the former to encourage higher birth rates among the white, educated, and native-born; the latter to discourage births among "inferior" people. Reaching its height in the 1930s, the eugenics movement subsequently fell from favor as a result of Nazi atrocities. Few experts were entirely immune from the appeal of "scientific breeding" in the early years, however. Having insisted on very clear differences between birth control and eugenics movements in 1919, for example, Margaret Sanger argued in 1926 that the national origins quota acts did not go far enough in controlling the quality of the population. Measures were needed, she said, to "cut down the rapid multiplication of the unfit and undesirable at home" (quoted in Hodgson 1991:15).

Paralleling the trend toward professionalism in the United States, the Malthusian League in England dissolved itself at the end of 1927 on the grounds that the principle of birth control was now widely accepted (Fryer 1965:250–253). In 1930, the National Birth Control Council was established to coordinate the work of existing societies and promote scientific contraception. With the amalgamation of several other societies in 1939, the British organization adopted a new name: the Family Planning Association, which corresponded more closely to the Association's activities.

By the 1930s, writes Linda Gordon, "the birth controllers had virtually ceased expressing any concern with the women's rights aspects of birth control" (Gordon 1976:310; see also Berkman 1979:32). It appears that a reformist women's movement had also abandoned the partnership. In

Great Britain, Canada, and the United States, laws regulating contraception that had been adopted on obscenity grounds were gradually being overturned. Women's organizations rarely took the lead in efforts to secure policy change, however (Field 1983). Although English women's groups at the Labour Women's Conference in 1925 and the Women's National Liberal Federation in 1927 passed resolutions supporting the provision of birth control advice at public maternity centers, in the United States neither the National Woman's Party nor the League of Women Voters were willing to risk association with the issue. Meanwhile, France and Belgium had passed restrictive laws forbidding the sale of contraceptives in an attempt to counter their declining birth rates, while Italy and Germany were increasingly advancing pronatalist measures under fascist regimes. Although the predominantly liberal legislation in Scandinavia remained intact, Stalinism was to threaten contraception and abortion rights in the Soviet Union.

During the 1940s and 1950s, birth control services in the United States were mainstreamed under the organizational umbrella of the Planned Parenthood Federation of America. Family planning was not accepted everywhere, however. In Louisiana, for example, there were no public or private birth control clinics in the early 1960s and the state criminal code made it a felony for physicians or others to disseminate information about any contraceptive method (Ward 1986:3). But, in general, although a number of state legal codes still blocked access to information and services, and although the Roman Catholic church remained firmly opposed, contraception for married couples as a means to responsible parenthood and even to sexual happiness had become respectable (Piotrow 1973:23–29).

Important new contraceptive methods also made their appearance. The progesterone pill, developed in 1953 after extensive earlier experimentation, was tested on a large scale in Puerto Rico in 1956 and approved for commercial distribution by the U.S. Food and Drug Administration in 1960. By 1965, 4 million American women were using oral contraceptives and, in the late 1960s, perhaps 12 to 15 million women worldwide (Seaman 1969:12). The intra-uterine device (IUD), different forms of which had been invented earlier in Germany and Japan, appeared in a new guise in the 1950s and was about to be incorporated into national family planning programs of Taiwan, Republic of Korea, Hong Kong, Singapore, India, and Pakistan (Piotrow 1973:97). Techniques of male and female sterilization as well as of identifying a woman's fertile period for practicing the rhythm method were improving. In combination with other attitudinal and demographic changes, the widespread acceptability and use of contraception undoubtedly contributed to the resurgence of feminism in the late 1960s and to the articulation of the movement's demands (Gordon 1976; Davis and van den Oever 1982).

SECOND WAVE FEMINISTS: NEW ISSUES, NEW CONTROVERSIES

The second wave of feminism swept North America and Western Europe in the late 1960s and 1970s, stimulated in part by Simone de Beauvoir's book *The Second Sex* (1949) and Betty Friedan's *The Feminine Mystique* (1963). Both books—among many others to follow—offered critical (although very different) analyses of women's subordination.

In the United States, the movement for "women's liberation" took three forms (Hole and Levine 1971). First, feminists founded the National Organization for Women (NOW) in 1966, a predominantly liberal-reformist organization of women and men supporting a broad range of women's rights. Similar organizations and caucuses were soon to follow within academic institutions, bureaucracies, and professional associations. Second, hundreds of small, independent, leaderless groups of radical feminists burst into bloom throughout the country to engage in personal consciousness raising and "guerilla" political activism. Third, women's caucuses emerged from new left, civil rights, and anti-war groups to challenge male leadership and debate gender-based as well as class- and race-based sources of oppression. The demands of the women's liberation movement ranged from economic and political rights to sexual and reproductive rights; from the transformation of intimate interpersonal and family relationships to institutional structures to national and international public policies.

The intensifying abortion controversy in the 1960s galvanized this second wave of American feminists around the issue of establishing and protecting women's reproductive rights, just as the struggle for liberal abortion and divorce laws was to unite European feminists of otherwise diverse views during the 1970s in countries such as England, Italy, and France (Bassnett 1986; Duchen 1986). The 1960s witnessed two additional developments in the domestic and international birth control movements that mobilized some feminists. The first was the rapid spread of new contraceptive techniques such as female hormonal methods and the IUD. Women's health advocates concerned with contraceptive safety disliked the direction the new technology was taking. Although the effective new methods offered more choice to some women, they carried the seeds of coercion and harm for others. The second development was the U.S. government's new enthusiasm for family planning as an anti-poverty measure at home and abroad, backed by a strong contingent of "population controllers" in the family planning organizations, foundations, academia, and federal and state legislatures. Feminists found themselves torn between their advocacy of reproductive control for all women and their distaste for the anti-feminist methods and neo-Malthusian motives of the population control movement.

THE STRUGGLE FOR ABORTION RIGHTS

Widespread legal prohibitions on abortion were largely a feature of laws and statutes adopted in Europe and North America throughout the nineteenth century (Field 1983:62–67). Abortion apparently raised little official concern before that, and the first definitive Papal condemnation did not occur until 1869. Nineteenth-century bourgeois feminists were not ardent supporters of abortion rights: they saw abortion and contraception "as symptoms of women's sexual exploitation rather than means toward the 'right to choose' motherhood" (Petchesky 1984:76). Sanger herself was ambivalent. Distressed with the dangers of clandestine abortion, she chose to advance legal contraception as an alternative rather than to promote safe abortion as a right. In this she departed from the demands of other radical and socialist feminists who insisted that women had a fundamental right to free abortion on demand.

With the exception of the Soviet Union, movements for liberalization emerged first in Scandinavia and Iceland during the 1930s and 1940s. Almost all Eastern European countries liberalized their abortion laws in the 1950s. In 1960, Spain, Italy, France, Ireland, Canada, and most of the United States retained the most restrictive laws, permitting abortion only to save a woman's life. At the other end of the spectrum, several Eastern European countries and the Soviet Union granted abortion on request or for broad social or health reasons (Field 1983: 25–26). Legislation in other European countries allowed abortion under more narrowly defined conditions. Abortion (and divorce) laws were liberalized under the impetus of various special interest reform groups in many countries during the 1960s and 1970s, including the United States.

In 1962, the American Law Institute proposed a model code that would provide for abortion on certain health, eugenic, and ethical grounds as approved by a physician (Luker 1984:66–91). The intent was to "rationalize" and standardize abortion laws across the states. (Similar efforts were addressed to divorce laws and other civil and criminal codes.) Initiated by legal reformers, the movement for abortion law reform was supported by liberal legislators, physicians, public health professionals, the family planning establishment, and many civic and church groups. Organized women's groups played little part in the early years, although some radical feminists had been working underground to help women who needed an illegal abortion.

In the heady atmosphere of social protest that was developing in the 1960s, abortion rights soon became a feminist issue (Hole and Levine 1971:278–302; Petchesky 1984:125–132). Reformers, fearing that radical feminist rhetoric might jeopardize their cause, were not overjoyed (Faux 1988:209). It was not *reform* feminists wanted, but *total repeal* of all laws regulating abortion. "Abortion, they said, should be of concern only to

the woman herself; physicians and other 'authorities' had no right to intervene. . . . [Feminists] wanted to redefine how abortion decisions should be made and who should make them; they wanted, in fact, to redefine the ground rules on abortion that had held sway for centuries" (Luker 1984:95). Reflecting the earlier arguments of radical and socialist feminists, the women's movement defined abortion as a woman's unconditional *right* requiring no legal, social, or medical justification. The right to freely obtained abortion, they argued, was essential to individual freedom, sexual liberation, and gender equality.

By 1970, recommendations for repeal of restrictive abortion laws were sweeping the country. Supporters of liberalization or repeal included NOW, Planned Parenthood, the Young Women's Christian Association (YWCA), the League of Women Voters, the American Civil Liberties Union (ACLU), the newly formed National Association to Repeal Abortion Laws (NARAL), the Unitarian Church, and the American Baptist Convention, among other organizations (Field 1983:81; Faux 1988). Twelve states reformed their abortion laws between 1967 and 1973, with four permitting abortion virtually on request. In response, a nascent right-to-life movement mobilized coalitions of political conservatives and religious fundamentalists opposed to reform or repeal, and the bitter fight that preceded (and followed) the Supreme Court's 1973 decision in Roe v. Wade was fully launched (Piotrow 1973:190–198).

In Roe v. Wade, which decriminalized abortion throughout the United States, the court found that a *right of privacy* inherent in the concept of personal liberty could be logically extended from a married couple's decision to use contraceptives (established in Griswold v. Connecticut, 1961) to a woman's decision to terminate a pregnancy. But the right was not unqualified. Although the state could not intervene during the first trimester of pregnancy, it had a "compelling interest" in later stages in protecting the woman's health and a "potential life" (Faux 1988:298–299). The responsibility rested with the physician. Roe v. Wade did not establish a woman's right *not* to bear a child against her will, nor did it remove the element of legal-medical control (Petchesky 1984:289–294).

The right to abortion in the United States under specified conditions was established (however precariously) as an individual *freedom*, not an entitlement. It carried no corresponding obligation on the part of a physician or hospital to perform one. In 1982, only 16 percent of all public hospitals in the United States performed abortions at all, and only 26 percent of non-Catholic general hospitals. Nor was the state obliged to pay. In the same year as Roe v. Wade, the U.S. Congress passed the Helms Amendment to the Foreign Assistance Act prohibiting the direct use of U.S.-foreign aid funds for abortion services in recipient nations (Fox 1986:641–643). Similar prohibitions were attached to the federal funding of abortions in the United States. Many state legislatures followed

suit; as a result, impoverished women in most states could not obtain subsidized services. The years since 1973 have been marked by continued legislative and legal assaults on abortion rights in the states, in Congress, and in the Supreme Court (NARAL Foundation 1991).

The battle over abortion in the United States and other Western countries has made feminists uneasy with their dependence on legal and legislative initiatives for rights they consider fundamental. Major legal decisions on access to contraception and abortion have been based largely on non-feminist grounds. Liberal policies and statutes are vulnerable to erosion or reversal as the political winds change direction. Although by the late 1980s women could obtain abortions on broad health or social grounds or on request in all but two countries in North America and Europe (Henshaw and Morrow 1990), the "legalistic bias" of these achievements made them seem fragile in the face of political opposition and weak or nonexistent support for the principle of safe and legal abortion at the international level. "The contradiction," feminists noted, "lies in being forced into the uneasy position of appealing to an unsympathetic government to create and protect our 'legal' rights" (Clark and Wolfson 1984:116).

Many feminists have also been uneasy with the single-issue politics of the abortion movement, insisting that greater attention must be paid to winning grass roots support for a full range of reproductive (and economic and social) rights and freedoms (e.g., Fried 1990). Socialist feminists charged the liberal women's movement in the United States with insensitivity to the concerns of poor and working-class women and women of color, both at home and abroad (Davis 1981:202–221; Clark and Wolfson 1984). "Birth control—individual choice, safe contraceptive methods, as well as abortions when necessary—is a fundamental prerequisite for the emancipation of women," writes Angela Davis in *Women, Race and Class*. The inability of middle-class feminists to unite women of different social backgrounds around this issue has resulted from their failure to popularize the genuine concerns of working-class women, and from the historical record of the birth control movement which "leaves much to be desired in the realm of challenges to racism and class exploitation" (Davis 1981:202–203).

RESISTING THE MEDICALIZATION OF CONTRACEPTIVE TECHNOLOGY AND SERVICES

The feminist critique of medicalization has focused on two related issues: the health risks and neglect of women's interests in the development of new birth control technology, and the appropriation of technology and service delivery by physicians. An emerging women's health movement in the late 1960s and 1970s, represented in the United States by the Na-

tional Women's Health Movement, contributed early critiques. Since then, a growing network of domestic and international women's health advocates has continued to confront established institutions on these and other concerns, including groups such as the Women's Global Network on Reproductive Rights (based in Amsterdam) and the International Women's Health Coalition (based in New York).

The *contraceptive safety* issue raises several related points. First, feminists charge that women's health advocates have had no say in the development of fertility regulating methods such as hormonal pills, IUDs, female sterilization—and, more recently, hormonal injections and implants—or in designing and staffing the experimental tests and delivery systems for these methods. Decisions have been made by the drug industry and by scientists and doctors in the population and biomedical professions who are promoting their own interests. Women as a political constituency are simply not considered (Seaman 1969; Jaquette and Staudt 1985). Second, feminists charge that most research has been done on female methods because male scientists are reluctant to pursue technologies that put men at any risk of side effects or that might be perceived as interfering with male sexuality (Frankfort 1972:22; Gray 1974:171–173). Research on acceptability pays no attention to female sexuality and little attention to certain side effects which, although not life-threatening, can cause women great anxiety. Third, both research and service delivery are dominated by an "inoculation mentality" in which the best method for most women (especially the poor) is viewed as a single anti-pregnancy "shot" such as an IUD insertion, injection, implant, or tubectomy (Joffe 1986:24–26). The reproductive concerns of women themselves are largely neglected in the scientists' quest for the perfectly effective, provider-controlled method.

Fourth, the effectiveness of hormonal and surgical methods has been purchased at the cost of significant dangers to the health or even the life of some users, feminists charge, especially in the early years of high-dose estrogen pills and injections and unsafe IUDs. Yet, medical professionals insist that the risks of preventing a birth must be weighed against the even higher risks to poor women—especially those in developing countries—of unsafe childbirth and clandestine abortion. Women's health advocates find this comparison insulting and unfair (Holmes 1979:4–5; Hartmann 1987:168–175), particularly in view of the limited resources devoted to primary health care in most countries (Germain 1987). Researchers and service providers should place more emphasis on mechanical and chemical barrier methods such as diaphragms and spermicidal foams, they contend, and on traditional methods such as withdrawal and periodic abstinence. Although less effective, these methods are generally without side effects (Bruce and Shearer 1979; Bruce 1987). Safe, legal abortion must be available as a backup for contraceptive failure and as a basic right.

Fifth, feminists have objected to the conditions under which many field tests of new contraceptives have been performed in both industrialized and developing countries. Of critical importance is the lack of genuinely informed consent and the apparent overrepresentation of vulnerable groups (the poor, the uneducated, racial or ethnic minorities) among experimental "subjects" (Ruzek 1978:36–47; Hartmann 1987). Sixth, new contraceptive methods requiring considerable skills and surveillance on the part of service providers are often introduced into settings with inadequate health infrastructures, thus exposing women to unnecessary risks of side effects and unwanted pregnancies (WHO 1991).

In the same vein, feminists have accused clinic-based family planning programs of pushing female methods at the expense of condoms or vasectomy. Although some women undoubtedly benefit from achieving greater reproductive autonomy, they also assume the sole responsibility for, and health risks of, fertility regulation. Sanger had pronounced this outcome inevitable. "In an ideal society," she wrote, "... birth control would become the concern of the man as well as the woman. The hard, inescapable fact which we encounter to-day is that man has not only refused any such responsibility, but has individually and collectively sought to prevent woman from obtaining knowledge by which she could assume this responsibility for herself" (Sanger 1920:93). Modern-day feminists found that husbands and lovers seemed eager to shift the responsibility for birth control to women while at the same time benefiting from greater sexual access. Some insist with their nineteenth-century counterparts that only natural family planning (periodic abstinence) is safe and acceptable. Others, although committed to furthering research on male methods so that men can share the responsibility for birth control and sexually transmitted disease prevention more equitably, are reluctant to depend on their male partners and want to maintain this control for themselves.

The *medical-hierarchical model of service delivery* constitutes a second theme of the critique. Sanger's efforts to win over the medical establishment undoubtedly helped to legitimize artificial methods of birth control on health grounds and to broaden women's access to services, but at a cost. Feminists haye objected to the medicalization of contraceptive service delivery because it signifies a loss of female control and feminist consciousness, just as they have objected to the medicalization of childbirth in Europe and North America and to medical control over abortion and women's reproductive health in general (Ruzek 1978; Rothman 1982). When Marie Stopes opened her British clinic in 1921, for instance, the medical profession challenged her failure to have a qualified gynecologist in attendance all day (cervical caps were fitted by nurses) and even her right to use the word "clinic" (Fryer 1965: 229). Doctors have long insisted on their professional perogative to control service delivery even when

female paramedical personnel could do the job as well or better. The campaign by physicians' associations to penalize paramedical or lay providers of medical services continues almost everywhere: in most countries only licensed doctors can prescribe pills, sterilize clients, or perform abortions.

Women's health activists in the United States, in other industrialized countries, and in some developing countries have experimented with alternative models of health care delivery (Ruzek 1978; Jones, Toss, and Scottish Health Education Group 1987). "Alternative" in this sense generally refers to women-controlled, non-hierarchically organized health centers that include abortion and birthing services, feminist therapy, and rape crisis counseling in the context of meeting women's needs for a broad range of sexual and reproductive information, support, and advocacy (Simmons, Kay and Regan 1984:624). The concept of self-help, promoted through the publication of books such as *Our Bodies, Ourselves* by the Boston Women's Health Book Collective (1973, 1984) and translated into many languages, is intended to circumvent the *traditional-authoritarian* model of service delivery in which "patients" are passive recipients of "expert" advice with which they are expected to "comply." Two feminist models are offered in its place (Ruzek 1978:104–112). In the *traditional-feminist* model, female para-professionals provide much of the reproductive health care to clients in an atmosphere of mutual respect and egalitarianism, thus reducing the potential for (usually male) physician control. In the *radical-feminist* model, women are encouraged to assume major responsibility for their own care with the assistance of lay women facilitators who are usually members of a health care collective. Feminists have also attempted to transform service delivery in *traditional-authoritian* family planning clinics in the United States (Joffe 1986; Ward 1986) and in some developing countries by introducing sexuality counseling by the woman's peers, sensitivity training of male and female staff, and woman-to-woman community outreach, among other reforms.

Professionalized, mystified, elitist, hierarchical, male-dominated, and often profit-oriented, medicalization is a top-down approach that—in the views of feminist health advocates—tends to *displace* paramedical personnel and traditional health practitioners such as midwives; *denigrate* women's knowledge about their own bodies, their own lives, and their own needs; and *deny* the reality of women's experience. This is not to romanticize women's traditional knowledge and skills, for some indigenous reproductive health practices are extremely harmful and others are harmless but ineffective (e.g., Hull 1979; Newman 1985). The feminist critique nevertheless raises a critical point about the locus of decisions regarding women's reproductive lives and, quite literally, about the control of medical professionals over women's bodies.

CHALLENGING THE DEMOGRAPHIC IMPERATIVE

The third development that caused feminists in North America and Europe as well as in southern countries considerable alarm from the 1960s onward was the growing preoccupation of many birth control supporters with the cause of population control. Drawing in part on nineteenth-century Malthusian theories, concerns about the rapid growth of population as a cause of poverty on the individual and family level and of economic underdevelopment on the national level burgeoned in the United States and internationally in the 1960s and 1970s (see chapter 3). In the United States, subsidized family planning was to become a centerpiece of President Lyndon Johnson's domestic War on Poverty in the mid 1960s. Although a number of scientific and political leaders and domestic organizations such as Zero Population Growth (ZPG) advocated birth rate reductions within the United States, the demographic imperative was most pronounced as a basis for U.S. foreign aid to developing countries. The Office of Population of the U.S. Agency for International Development (USAID) was soon to launch its "inundation strategy" to make contraceptives and sterilization available to all couples who wanted them (and some who did not) in developing countries. The U.S. delegation to the United Nations World Population Conference in Bucharest in 1974 argued strongly for an international policy setting demographic targets for reductions in population growth.

Once again, feminists were caught in a dilemma. On the one hand, subsidized services for low-income women at home and USAID's inundation approach abroad benefited women by broadening the range and accessibility of birth control information and services. Governments and non-governmental organizations (NGOs) created infrastructures for delivering family planning and, in the best programs, other reproductive health services to previously unserved populations, especially in rural areas. In the United States, the "great experiment" in subsidized family planning had developed by the early 1970s into a major system for the delivery of preventive health care to women of low or marginal incomes (Ward 1986:74). In many developing countries the numbers of women claiming to know of at least one "modern" method of family planning soared while contraceptive prevalence rates rose steadily. The emphasis on reaching large numbers of acceptors helped to undermine physicians' control over contraception by extending services through networks of health and family planning clinics, paramedical personnel, and community motivators, many of whom were women. Services were also increasingly delivered through commercial and community channels. The demographic imperative helped to mobilize medical science to develop more effective contraceptives and simpler techniques of abortion (e.g., vacuum aspira-

tion by hand-held syringe, hormonal pills) and male and female sterilization (e.g., female minilaparascopy) that could be performed by paramedics.

From a feminist perspective, however, the demographic bias of the expanded birth control movement was damaging to women's interests. Women of childbearing age—especially if they were poor—were targeted as "at risk reproducers" with little if any understanding of, or concern for, their social and economic survival and security (Jaquette and Staudt 1985). Few population experts appeared to recognize that a reduction in fertility in the absence of other social changes could actually worsen, rather than improve, women's position in societies where childbearing is their main source of satisfaction and exclusive claim to social consideration as an adult woman (Tangri 1976:902; see also chapter 6). Moreoever, some authoritarian governments seemed eager to promote population control in the absence of any genuine social, economic, or political reform; in this sense, the political context rather than the services themselves were unacceptable.

Within most family planning programs, the *quality* of reproductive health services was sacrificed to the *quantity* of family planning acceptors, the safety of contraceptive methods sacrificed to efficiency and technical effectiveness (Seaman 1969). Quantitative goals in service delivery were measured in numbers of acceptors, contraceptive prevalence rates, couple-years of protection, and—at the bottom line—numbers of "births averted." Governments and service providers appeared preoccupied with limiting family size ("stop at two" campaigns, for example) rather than with meeting women's traditional interest in child spacing or their fears of subfecundity or sterility. Excesses among overenthusiastic governments and overzealous community motivators eager to reach their targeted numbers of IUD or sterilization acceptors were common (Warwick 1982; Hartmann 1987). Providers often promoted long-lasting methods such as the IUD, injectables, or sterilization over methods that a woman could easily stop or switch on her own. Some providers believed that nonliterate women could not use other methods correctly; others were receiving incentive payments for persuading clients to accept IUDs or sterilization. Providers often failed to advise clients about possible side effects or contra-indications for fear that this would discourage them from adopting a method. At the same time, the rapidly expanding market for contraception in southern countries (much of it supplied by USAID or its grantees), combined with heightened concerns about liability litigation in the United States, encouraged some cases of corporate dumping overseas of contraceptives that were no longer in use (or never approved for use) in the U.S. domestic market, such as high estrogen orals, the Dalkon Shield IUD, and injectable Depo-Provera (Ehrenreich, Dowie and Minkin 1979).

More generally, feminists charged that the world view of population planners focused too narrowly on women's "excess fertility" without paying sufficient attention to the entire pronatalist and discriminatory system within which women live. Even those demographers who were aware of the pronatalist implications of gender inequality (e.g., Davis 1967) often proposed policy solutions that would intensify rather than reduce the conflicts most women experienced between their productive and reproductive roles. At the same time, the single-minded preoccupation of the population controllers with averting births neglected women's other vital health concerns (Germain and Ordway 1989). The concept of birth control as potentially liberating for women and for the poor, which was so central to radical and socialist feminism in the early part of the century, had been submerged.

Ultimately, the feminist critique of the demographic imperative rests on the conviction that women have a right to make their own decisions and to "own and control" their own bodies without governmental intervention. Women will make rational choices if they have the information and resources. Feminists have spoken out against program abuses and against the underlying ideologies of population control. As described more fully in the next chapter, however, women's views and concerns were scarcely represented in the bureaucracies of the population controllers—in the research centers, the corporations producing the contraceptive technologies, the medical establishments, the foundations, the legislatures; the governmental and nongovernmental agencies. It seemed that women had lost control over their own bodies to these outside agents at the same time that they were finally able to plan whether and when to bear children.

8

WOMEN'S RIGHTS AND REPRODUCTIVE HEALTH: A POLICY AGENDA

One of the major challenges for feminists and others concerned with population and human rights has been to formulate a set of principles on which population policies and family planning programs could be based. The women's movement in the south and the north has raised its voice in opposition both to the crisis mentality of the antinatalist forces, which can lead to program abuses and distortions in funding, and to the crusading mentality of the pronatalist forces who often draw on ethnic, religious, or nationalist ideologies in their exhortations to be fruitful and multiply. Both approaches, when taken to extremes, result in violations of basic human rights. Both, too, degrade women by treating them as objects of manipulation rather than as subjects of their own fate.

What would a responsive reproductive policy and service delivery system look like? From an ethical standpoint, critics point out that policy choices must balance the demands of personal freedom, distributive justice, and security/survival (Callahan 1981; Macklin 1989). A feminist perspective stresses these themes with specific attention to women (Tangri 1976; Overall 1987). Given the ideological differences among feminists over many issues, it is not possible to draw up an agenda on which everyone can agree. As the international feminist group Development Alternatives with Women for a New Era (DAWN) emphasizes, "feminism cannot be monolithic in its issues, goals, and strategies, since it constitutes the political expression of the concerns and interests of women from different regions, classes, nationalities, and ethnic backgrounds. There is and must be a diversity of feminisms, responsive to the different needs

and concerns of different women" (Sen and Grown 1987:13). Nevertheless, it is possible to propose some general principles. The policy goal would be to empower women to gain control over their own sexual and reproductive capacities in the context of a broad program of social transformation that advances the freedom and security of women of all social classes. Fertility reduction is likely to result from these transformations, but it is not a primary goal.

Reproductive policies that are genuinely supportive of human rights recognize that personal freedoms and social entitlements are essential to the advancement of human welfare. They respond *not* to a crisis mentality about the perils of overpopulation, which can trigger damaging and ultimately self-defeating efforts at massive population control. Rather, they evolve from a thoughtful engagement of the difficulties women face around the world in their struggle to take control over their own fertility and their own lives. For many women in the world the most important aspect of reproductive freedom is to be able to *have* the children they want, and to be confident that their children will survive, be provided for, and go to school. For others the issue is to avoid unwanted childbearing. For these women, the choice of *whether and when* to have children and how many to have is still to be realized. There is much to be done, not only in the broader context of transforming the material and social conditions that shape reproductive decision making, but also in the more specific context of providing high quality reproductive health services for all who need them.

This chapter proposes a framework for thinking about population policies that departs from the conventional view. It builds on the ideas presented at the outset which traced the evolution of two "streams of thought." The first stream was the historical development of ideas about human rights, which were subsequently elaborated as ideas about equal rights for women and men and, more recently, as ideas about reproductive rights and freedoms. The second stream of thought evolved from ideas about economic growth (e.g., the "wealth of nations"), to ideas about the role of population in development (e.g., "optimal populations"), to ideas about the role of family planning in controlling population growth. The evolutionary "arrows" flowed downward through time in the parallel streams:

human rights	economic growth
↓	↓
equal rights for women	population growth
↓	↓
reproductive rights	population control through family planning

Previous chapters have explored the relationships among ideas, social movements, policies, and practices in each of these areas. They have identified sources of conflict between advocates of women's rights on the

one hand and of population control on the other, and between supporters of reproductive freedom and of target-driven family planning. This final chapter brings the two streams of thought together. Introductory comments on the elements of a responsive reproductive policy lead to a critique of the conventional approach to population policy-making. The chapter continues with a proposal to substitute an *equal rights* policy for a population (reproductive) policy, a *reproductive rights* policy for a family planning policy, and a *reproductive health* program for a family planning program. Although the issues raised here are most relevant to antinatalist policies and programs in southern countries, they apply to the north as well.

TOWARD MORE RESPONSIVE REPRODUCTIVE POLICIES AND PROGRAMS

An ethical appraisal of a public policy includes two elements: (1) the procedural question of how policies are formulated and implemented, including the participation of those who will be most affected; and (2) the substantive question of the ethics of the policy itself, that is, its implications for freedom, distributive justice, and security/survival (Berelson and Lieberson 1979).

On the *procedural* question, the virtual exclusion of women as a major constituency from the policy-making process in many countries has intensified the antagonism of the women's movement toward many aspects of state reproductive policies and those of international agencies. In many cases this has led to misunderstandings on both sides. Politics is, by and large, a male game. Only 3.5 percent of ministries in 155 countries were headed by women in the late 1980s, and 99 countries had no women ministers at all (Appendix C). Women occupied fewer than 10 percent of legislative seats in 62 of 86 developing countries for which information is available and in 12 of 33 industrialized countries, including Canada, the United States, and the United Kingdom (United Nations 1991:39). The few women who rise to prominence within formal political and bureaucratic structures—as ministers of health and social welfare, for example—rarely express an explicit concern with empowering women. The reasons are understandable, Most successful women have been socialized into the norms of male-dominated professions, while those who appear "too biased" or "too feminist" find their career advancement blocked in all but exceptional circumstances. For these reasons, activists often select themselves out of establishment channels into positions permitting a more critical stance, such as academia or the organized women's movement. As discussed in chapter 4, women leaders and organizations are insisting on having their voices heard in the policy arena. They argue that because reproductive policies and programs affect women most deeply, women

must be key actors in the policy-making process. Ensuring the full participation of women's groups, particularly those representing the concerns of exploited classes in both rural and urban areas, becomes a defining element of an ethical policy.

The *substantive* question relates to policy and program content. To be effective, policy approaches must be tailored to the unique circumstances of each country as well as to the diversity of needs within each country. Speaking generally, however, let us consider the proposition that a responsive reproductive policy could create conditions favorable to lower fertility while expanding the exercise of human rights through three major avenues: (1) rights-oriented socioeconomic development; (2) equal rights for women; and (3) the promotion of reproductive health and rights. Following this logic, the previously separated streams of thought combine to create three new equations:

human rights	=	development policies
equal rights for women	=	population (reproductive) policies
reproductive rights and health	=	family planning policies and programs

Ideally, a population policy is part of an overarching *development policy* designed to advance human welfare through such means as employment and income generation, land reform, education, health services, social security, and the reduction of socioeconomic inequalities across countries, regions, and social classes. The intent is to extend to all persons an adequate standard of living together with other basic freedoms and entitlements. In this sense, *a development policy is a human rights policy.* Based on the principles of the Universal Declaration of Human Rights, it promotes social and economic rights; it broadens people's opportunities for survival, security, and mobility; it advocates distributional justice. Ideally, a development policy is a human rights policy in another sense as well: it advances individual freedoms by promoting civil and political rights.

Governments differ in the absolute and relative weights they place on social and economic rights as compared with civil and political rights. Some emphasize both (e.g., models of democratic socialism); some emphasize entitlements over freedoms (e.g., communist regimes); some emphasize freedoms over entitlements (e.g., democratic capitalism); some recognize neither (e.g., authoritarian regimes that enrich the elite and impoverish the masses). An antinatalist (or pronatalist) population policy enacted in the absence of a strategy to expand basic freedoms or entitlements is bound to be considered illegitimate by those who are its objects.

A second avenue of intervention is to promote the equal rights of women and men. In this formulation, *a population policy is an equal rights policy.* It advances women's economic and social rights and women's civil and

political rights; it works toward the elimination of all forms of discrimination against girls and women; it undermines pronatalist patriarchal relations in the family, community, and nation. Fertility reduction is not a primary goal, however; rather, it is a secondary outcome of an equal rights policy.

A third avenue of intervention targets specific areas of reproductive health and freedom within the larger framework of a human rights/equal rights policy. "Family planning" undergoes a metamorphosis: it transcends its conventional definition as a system for delivering contraceptive services to embrace a broader range of freedoms and entitlements. *A family planning policy is a reproductive rights policy* designed to ensure that women and men exercise the full range of reproductive rights to which they are, in principle, entitled. It protects individuals against infringements of their rights by both pro- and anti-family planning forces. Similarly, *a family planning program is a reproductive health program* designed to deliver a full range of high-quality sexual and reproductive health services to all who want and need them. The population control element of family planning vanishes with this transformation along with its targets of "contraceptive acceptors" and "births averted." Both are replaced by goals and targets linked directly to the achievement of gender equality and reproductive rights, that is, to the improvement of human welfare. As will be argued below, the "new look" should have a major demographic impact despite (or because of) the reformulation of policy goals.

WHAT IS WRONG WITH THE CONVENTIONAL POPULATION POLICY APPROACH?

A population policy is a deliberate effort by a national government to influence aggregate levels of fertility, mortality, and migration. As noted in chapter 1, it typically includes a reproductive policy, a health policy, and a policy relating to migration and population distribution. A typical policy statement begins with a *rationale* of why there is a population problem. For example, current or projected population growth rates may be said to pose serious obstacles to the achievement of a country's social and economic objectives (for country-specific examples, see Isaacs and Irvin 1991). Second, a statement includes a set of general *goals* and specific *objectives*, such as achieving a better balance of population and resources or improving overall standards of living by altering demographic behavior in specified ways. In some cases, timetables and targets are set for their achievement (e.g., to "achieve birth spacing practice of a minimum of three years by at least 50 percent of mothers by the year 2000," as in India; ibid. p. 13). Third, a policy statement sets forth specific measures for *implementation*, such as improving health and nutrition through com-

munity campaigns, slowing cityward migration by investing in rural infrastructures, strengthening family planning services, educating students and the general public on the country's population problems, improving the status of women through changes in their legal status, promoting research and evaluation, and so on (ibid.). Specific government ministries or other organizations are identified as the responsible agents for policy and program implementation.

The process by which population policies emerge in developing countries has drawn criticism from both supporters and detractors of the need for such policies. At the risk of oversimplification, let us consider a typical scenario (Godwin 1975; Roberts 1990; Thomas and Grindle 1990). In this model, demographers working with bilateral or multilateral donor agencies, research organizations, or consulting firms develop sophisticated statistical analyses of the impact of projected population growth rates and characteristics on the development prospects of a particular country. They highlight the difficulties of providing universal schooling and health care, raising per capita incomes, sustaining adequate food production and consumption, and conserving natural resources and the environment, among other issues. With these analyses in hand, experts working for donor organizations such as USAID, UNFPA, or the World Bank form alliances with like-minded local government officials, in-country researchers, or leaders of key NGOs such as family planning associations to propose policy solutions to recipient governments. A donor agency may appoint a population advisor to work with government planners to formulate and implement an "official" demographic policy. Political leaders are urged to make public statements in support of such a policy, with emphasis on the need to reduce birth rates through the promotion of family planning programs.

The process as described is technocratic, externally motivated, and apolitical. Consider, for example, the comments of USAID population experts on their early approach to policy-making in developing countries (Sinding and Hemmer 1975): "(1) [planners] *must be convinced* that some of the values they seek to maximize are unlikely to be advanced under existing demographic conditions; (2) *they must be convinced* that it is possible to affect the demographic variables, especially fertility, through the instruments of public policy; and (3) *they must be convinced* that specific policy measures have a good chance of producing the desired result" (emphases added). A less directive version describes a model of "linkage politics" in which networks of private and official international donors provide assistance to local groups working to establish a political environment conducive to the development of a national policy (Merrick 1990). More attention is paid here to mobilizing local support. National counterpart organizations and individuals who could be recruited for the cause include population researchers, private family planning associa-

tions, medical and family welfare associations, legislators, government officials in health and statistical units, and high-level public officials at the presidential and ministerial levels and in the military.

What is wrong with this picture? To the extent that it reflects reality, the model neglects the political constraints on decision makers such as scarce resources, competing demands, uncertain tenure, and political opposition. Defining planners as concerned with promoting the common good and finding optimal solutions based on a "neutral" analysis of "scientific" evidence (Dye 1972), it ignores the fact that governments are often more preoccupied with eliminating political opposition than with meeting the basic human needs of their people. The model implies that governments are incapable of initiating their own programs based on their own analyses and rationales. Conversely, it treats all governments as though they have the legitimacy, political will, and capacity to carry out their policy agendas, ignoring the possibility that new or weak states may have to bargain and compromise with powerful local leaders.

Most important, the scenario reflects a top-down process that relies on experts rather than on consultations with groups who will be most affected by policy decisions. Yet, as noted in chapter 1, people are likely to resist the imposition of state population policies and birth control programs that threaten their strategies for survival and security. Local leaders will intervene to protect their constituents, "in the process usurping the social control of the state and snuffing out compliance with its policies" (Greenhalgh 1990:10). Moreover, by perpetuating the false equation of family planning with population control, the technocratic approach distorts the purposes of both and fuels the fires of anti-family planning sentiment among potential clients and among critics from the right and the left. As a political scientist observes in her analysis of antinatalist policies in sub-Saharan Africa, "Religious officials, traditional sector leaders, minority ethnic groups, and nationalists can sense disadvantage and political ill will in the antinatalist choice. But it is rare that these variables figure, even marginally, in economic and demographic analysis" (Anglin 1975:174).

If the purpose of a demographic policy is to promote sustainable long-term development and improve the quality of life for all people, then the regulation of birth rates is a *means to an end* and not an end in itself. Measuring changes in fertility levels per se tells us little about the achievement of these broader goals. Similarly, if the purpose of reducing infant mortality and expanding people's opportunities for schooling, employment, better health and housing, old-age security, and other benefits is to improve human welfare, then these are *ends in themselves* and not a means to an end such as lower birth rates. Finally, if the purpose of providing family planning services is to enable couples and individuals to regulate their fertility in a safe, effective, and acceptable manner, then

this too is an *end in itself* and not a means to an end. Family planning is a social good and a right; it needs no other justification. Program achievements need to be measured in their own terms—as measures of client empowerment, knowledge, satisfaction, and welfare—and not in terms of a population control agenda.

FROM POPULATION CONTROL TO EQUAL RIGHTS

In what sense is an equal rights policy an antinatalist population policy? Its intent is to challenge explicitly those ideological and structural elements of "coercive pronatalism" that deny women genuine reproductive choice. These include early arranged marriage, female seclusion, sexual exploitation in the domestic and public realms, and gender-based discrimination in rights of property, family affairs, education, employment, and political life. Affecting women differentially by economic and social class but universally as a sexual class, patterns of female subordination are embedded, in various forms and degrees, in patriarchal family systems, in social, religious, economic, political, and legal systems, and in state policies in both developing and industrialized countries.

A woman's capacity to make independent choices about marriage, divorce, and childbearing is tied to her capacity for economic and social self-sufficiency. For this reason, a policy of *selective* investment in female schooling, vocational training, employment, and community organizing, which is widely recognized as an appropriate mechanism for accelerating de facto equality, may have a far greater impact on reproductive behavior (as well as on children's health and well being) than so-called gender-neutral investments that almost always favor males (Dixon 1978; Cochrane 1979; Caldwell 1986; Dwyer and Bruce 1988). Moving beyond equality of opportunity, a gender-focused policy would seek equality of results. Acquiring full legal rights is essential, but women need social and economic resources in order to activate them. As discussed in chapter 5, strategies for empowering girls and women include acquiring knowledge and skills, earning independent incomes, and mobilizing grass-roots and national organizations to advance their rights and protect their interests. The *substance* of an equal rights policy, then, is to devise means of promoting women's freedom and security/survival directly, which sets the stage for reproductive rights policies and programs. In contrast, a conventional population policy uses interventions such as socioeconomic investments and family planning programs as the means of reducing birth rates without close consideration of their implications for women's lives in particular contexts.

An equal rights policy, like a population policy, represents a commitment by a national government to institute specific changes. It includes a rationale (e.g., why discrimination against girls and women constitutes

a denial of human rights and an obstacle to development), goals and objectives, targets and timetables, and a plan for implementation. The U.N. Convention on the Elimination of All Forms of Discrimination Against Women offers a useful framework for a national equal rights policy. Ratified or acceded to by over 100 countries (Appendix D), the convention calls for governmental intervention to ensure that women enjoy on a basis of equality with men a full range of human rights and fundamental freedoms. In particular, it calls for states parties to institute laws and policies that will (1) eliminate customary practices and prejudices that discriminate against girls and women; (2) ensure women equal rights with men in political and public life and nationality; (3) ensure equal rights in all aspects of education; (4) eliminate discrimination against women in matters of employment, working conditions, benefits, and earnings, including protection against dismissal due to marriage or maternity; (5) accord women equality with men before the law, including full and independent legal status; (6) accord women equal rights at the time of marriage, during marriage, and at its dissolution; and (7) recognize the special problems faced by rural women and their need to participate in development planning, training and education, community organization, credit and land reform schemes, and other development efforts (Appendix A).

Reinforcing and adding to women's rights that have been spelled out in over a dozen international charters and conventions, the convention represents both an equal rights policy and a "women in development" policy. Its power has been weakened, however, by inadequate enforcement mechanisms and by numerous reservations filed by states parties that are intended to avoid confict with religious or customary laws (Cook 1990; Holt 1990). Because the abolition of customary laws and practices that discriminate against women is one of the jewels in the crown of the convention, such reservations render ratification almost meaningless. They are not surprising, however, for the document's preamble and substantive articles are intended to challenge the very foundations of patriarchy. This challenge is bound to elicit resistance from religious elites (in this case, most frequently the protectors of Islamic law) and from defenders of customary practices and laws in traditional non-Islamic societies (e.g., in sub-Saharan Africa). Religious personal status laws and unwritten customary laws almost invariably perpetuate male privilege and control over women in matters of sexuality, marriage, divorce, child custody, and inheritance. They also serve as powerful symbols of cultural identity and anti-Western sentiment (Freedman 1991; Kandiyoti 1991). Thus, Third World governments indebted to or captured by conservative religious or ethnic groups or nationalist movements are likely to protect the status of such laws even where civil codes guarantee equal rights for all citizens in the public sphere.

Ratification obliges states to bring their laws and policies into conformity with the convention's provisions and report periodically to a U.N. monitoring committee (International Women's Rights Action Watch 1988). Many countries have incorporated equal rights provisions in their constitutions (Appendix D), some of which precede the convention by many years. In addition, most governments and international aid agencies have adopted "official" feminist rhetoric by committing themselves—at least on paper, and with limited success—to policies promoting the integration or "mainstreaming" of women in all sectors of development and decision making (Staudt 1985, 1990; Carloni 1987; Duncan and Habib 1988). In conformity with the Forward-Looking Strategies of the U.N. Decade for Women, most governments have established national commissions on the status of women, women's divisions or ministries, and other agencies for monitoring progress and effecting change. The success of these endeavors depends on many factors, of course, and the outcome has been mixed.

An equal rights policy shares with a population control policy a number of problems. Even where the political will exists and the majority of citizens support the principle of equality, the wheels of legislative and policy reform turn slowly. Much depends on the structural and cultural characteristics of the legal system (Freedman 1991). States with powerful ruling families or strong governments may simply impose a policy of female emancipation in order to undermine patriarchal kin groups and communities or regional, ethnic, or religious influence, extend state control, and mobilize women's labor power and political support. Examples include Soviet control of central Asia (Massel 1974), the Democratic People's Republic of Yemen, Iran under Reza Shah, Egypt under Nasser, Iraq under the Ba'th party, and Turkey under Attaturk (Kandiyoti 1991). Weak states will have to bargain with opponents of women's rights; policy statements may reflect little more than accommodation to international political pressures with no intent to implement.

Ideally, however, an equal rights policy will involve a different *process* than the externally driven, top down, and technocratic approach described earlier. First, although policies and programs of equal rights and "women in development" are already in place in most countries, women's organizations in each country can articulate specific principles of most relevance to them and work for their implementation. The goal is to enable women in each country to understand how current laws and policies inhibit their participation in social and economic life and to determine ways in which women might use the political and legal system most effectively to secure their rights. The model is one of change from within. "The call for the granting of basic rights of choice to women and the methods used to secure them must come from within—from within the country itself,

and from within the terms that define that country's cultural reality" (Freedman 1991:28–29).

Second, whereas women's organizations in the south and the north have been wary of population control policies and critical of family planning program abuses, they are natural allies of measures designed to promote women's freedom and welfare. This is not to suggest that women's groups will see eye-to-eye on all issues, for the case studies in chapter 4 demonstrated that this is not the case. Women's organizations in countries where autonomous groups are permitted cover a spectrum of political, economic, and social orientations. Many are based on class, religious, regional, or ethnic identities. Yet, despite their many contradictions, organizations representing women's interests are likely to find some common ground on which to articulate their gender-based concerns and demands for action.

Third, an equal rights policy encourages coalition-building among researchers, government officials, legislators, and activists concerned with human rights issues, legal reform, family welfare, social justice, and development. Women's organizations and leaders can ally themselves with like-minded individuals and groups within their own countries while drawing on the support of women's movements in other southern countries, in the north, and in international agencies. State ratification of the convention offers a useful organizing tool and focus. NGOs can play a central role in monitoring governmental action or inaction in compliance with its terms, at the same time organizing grass-roots activities to mobilize women of all classes and inform them of their rights. In collaboration with national commissions or women's ministries, NGOs can produce and disseminate a culturally specific "girls' and women's bill of rights" to raise the consciousness of key groups in each country, particularly of women in marginalized circumstances. Freedoms and entitlements to be included in such a bill of rights cover not only those items mentioned in the convention, but also sexual and reproductive rights to be elaborated in each cultural context.

FROM FAMILY PLANNING TO REPRODUCTIVE RIGHTS

A reproductive rights policy is embedded in a human rights/equal rights policy. It sets the legal and structural framework within which women and men are able to exercise their right to sexual and reproductive self-determination and obtain the information and services they need.

Governments may support a conventional family planning policy on demographic or health grounds, on grounds of human rights or women's status, or for reasons of social justice and human welfare. In essence, the mission of a family planning policy is to support the provision of birth

control information and services through public and private sector initiatives. A widely cited scheme for assessing the strength of national family planning program efforts cites eight "policy and stage-setting activities" (Mauldin and Lapham 1987). Five involve the mobilization of governmental support for family planning through official policy rationales, supportive statements from leaders, high-level bureaucratic location of national program leadership, integration of other ministries and government agencies, and budgetary support. China's policy and stage-setting score far exceeds that of other developing countries in this scheme, followed by India, Indonesia, the Republic of Korea, and Mexico as the next strongest (ibid.:564). The implication is that a strong demographic mandate contributes to a strong family planning program..

This implication, however, lies at the heart of the confusion about (and political resistance to) the purpose of family planning. As Judith Bruce points out, "tension [is] created when family planning services are caught between two potentially conflicting mandates: promoting the achievement of demographic objectives and meeting individual health and welfare needs" (Bruce 1990:63) If family planning programs could be unhooked from their demographic mandate, they could focus more clearly on meeting individual needs and providing a range of sexual and reproductive health care. At the same time, a *reproductive rights policy* could provide a framework for ensuring that women and men are protected from infringements on their freedom by *both* antinatalist and pronatalist forces. No one could be denied their right to use a contraceptive method, for example, or to terminate an unwanted pregnancy. At the same time, no one could be forced to use a method (e.g., compulsory sterilization), or persuaded to do so under false pretenses (e.g., by withholding information about side effects), or prevented from stopping a method (e.g., by refusing to remove a contraceptive implant). Any of these actions would involve a violation of basic rights. This formulation is consistent with the 1989 Health Law of Vietnam, for example, which stresses that all individuals must be free to choose the family planning method they wish and declares that "all acts of preventing or forcing the implementation of family planning are prohibited" (Allman et al. 1991:314).

A reproductive rights policy would lay the groundwork for freedom of choice in marriage and divorce, in sexual relations more generally, and in the use of birth control methods. *Marriage laws* and policies backed up by public information campaigns could prohibit the betrothal of young girls; set a minimum age at marriage of at least 18 years for both sexes and require their free and full consent; regulate the size of brideprice and dowry payments which reinforce kinship controls over the bride; ensure that a husband in a polygynous marriage can take a second wife only with the first wife's agreement in court; ensure that a wife can initiate and obtain a divorce on the same grounds as her husband; eliminate divorce

by unilateral repudiation of the wife; and establish a woman's right to the custody of young children and financial support following divorce. A father's obligation to support his children would be enforced. *Laws relating to sexual behavior* would attach criminal penalties to incest and the sexual abuse of children; rape and other forms of physical violence; sexual intercourse with under-age females; and recruitment for and profiting from prostitution and sexual slavery. At the same time, homosexual relations between consenting adults and heterosexual relations between consenting unmarried adults would be decriminalized. *Laws on contraceptives* would legalize the importation, manufacture, distribution, and advertising of contraceptives while maintaining appropriate standards of quality control (Isaacs and Cook 1984). They would facilitate the provision of services and supplies by trained non-physicians such as midwives, nurses, and pharmacists. Restrictions on sexual and birth control information and services for adolescents or unmarried people would be repealed (Roemer and Paxman 1985) along with requirements of spousal or parental consent (Cook and Maine 1987). *Voluntary sterilization and abortion* would be legalized on request while maintaining appropriate medical standards and ensuring fully informed consent. Special incentive payments to providers of family planning methods such as IUDs or sterilization, "motivators," and "acceptors" would be eliminated in order to reduce the potential for program abuses. Independent commissions would be established to investigate complaints of coercive, negligent, or other harmful practices of family planning researchers or providers in the public and private sectors and assist clients in protecting their rights.

These are examples of what might be included in a reproductive rights policy. Coalitions of women's groups, human rights advocates, and family planners in each country could draw up a set of principles to guide reproductive laws and policies. The purpose of such a policy is to provide a "shelter" of rights within which people's sexual and reproductive health needs can be fully addressed.

REPRODUCTIVE HEALTH AS A CORE PROGRAM

The concept of reproductive health has gained currency in the 1980s as a symbol of a fresh perspective on women's rights and family planning (e.g., Germain 1987; Germain and Ordway 1989). It incorporates elements of conventional approaches to health and family planning service delivery while broadening their scope and deepening their impact. The concept of reproductive health is premised on the feminist principle that every woman has the right to control her own sexuality and reproduction without discrimination as to age, marital status, income, or other considerations. Ensuring the highest possible standards of reproductive health care for girls and women is fundamental to the exercise of their reproductive rights

and freedoms, and to the exercise of the broad array of other human rights to which girls and women are entitled.

Reproductive health refers to a woman's ability (1) to understand and enjoy her own sexuality by gaining knowledge of her own body, her sexual capacities, and her sexual rights; (2) to regulate her fertility safely and effectively by conceiving only when desired, by terminating unwanted pregnancies, and by carrying wanted pregnancies to term; (3) to remain free of disease, disability, or death associated with her sexuality and reproduction; and (4) to bear and raise healthy children (adapted from Germain and Ordway 1989). By laying out these principles, we can see that a reproductive health program involves much more than the delivery of maternal and child health (MCH) or family planning services as conventionally defined.

Reproductive health incorporates a clear feminist and human rights focus for its full realization. It moves birth control out from under the umbrella of "family planning" and "planned parenthood," with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health. It links and transforms existing services in a manner that places women's physical and emotional security at the center. It broadens the concepts of "user's perspective" (or client's perspective) and "quality of care" (Bruce 1980, 1990; Ainsworth 1985)—both of which represent significant advances over earlier thinking—to encompass an agenda for social transformation. It recognizes that reproductive autonomy cannot be obtained by means of birth control alone, even when delivered in a comprehensive and caring way.

The reproductive health framework also helps to move family planners away from their preoccupation with contraceptive acceptance rates and births averted, a preoccupation that has led to charges that singling out "excess fertility" as the most urgent problem represents a cynical disregard for the multiplicity of women's needs (Karkal and Pandey 1989). At the same time, it can move health workers away from their sometimes narrow conception of *maternal* morbidity and mortality to consider a broader range of social and health issues (Sai and Nassim 1989). As noted in chapter 6, reproductive health is consistent with the concepts of *reproductive* mortality and morbidity which involve calculations of the health risks and benefits of sexual behavior and of attempts to prevent pregnancy as well as of pregnancy and childbirth. Perhaps most important, a reproductive health framework elicits positive connotations of health and reproduction rather than negative connotations of fertility control.

A comprehensive program of reproductive health and rights based on feminist principles would (1) build on and learn from women's experience; (2) empower women to overcome their oppression; (3) offer an appropriate array of reproductive health services; (4) ensure fully informed choice of birth control methods, including abortion; (5) offer a choice among deliv-

ery systems and providers; (6) provide individual and group counseling and educational programs; (7) reach into the community to change discriminatory attitudes and practices; (8) build linkages with related programs and providers; (9) institute staff training in accountability and philosophy of care; and (10) draw on a sustained commitment from governments, NGOs, and bilateral and multilateral funding agencies. Each of these points is elaborated briefly below.

1. *Building on women's experiences*

Building on and learning from women's experiences is an essential first step in creating a woman-centered reproductive health program. In essence, this means that clinic- or community-based programs would be designed, in large part, *by* women *for* women. Men would not be excluded from sharing the responsibility for practicing birth control or from providing or receiving services; far from it. Culturally sensitive educational and service programs designed by men for men are essential (Gallen 1986). Rather, programs intended primarily for female clients would be planned, implemented, and evaluated with the full participation of women at all levels and stages of decision making. (For a useful analysis of concepts and measures of client participation, see Cohen and Uphoff 1977.)

Involving representatives of client populations in the design and assessment of decentralized community services will ensure that reproductive health programs are informed by women's perceptions of their own needs and priorities in each setting. Women can draw on their experiences with health care and family planning providers such as herbalists, pharmacists, traditional midwives, and physicians and paramedics in the public and private sectors. In a woman-centered program, what the *client* knows about her personal history, health and family planning needs, and about the attitudes of her family and community is just as important as what the *provider* knows about technical topics such as the relative risks of different contraceptives or how a method works (Bruce 1983:51; see also Lipton, Dixon-Mueller and Brindis 1987). Program clients would participate directly in the evaluation of the services they receive through informal group consultations, serving as community advisors, and other means.

Reproductive health programs would be adapted to the specific needs of the women they serve, derived from a fundamental understanding of women's lives in diverse economic and cultural circumstances. Recognizing the centrality of childbearing to women's security and self-esteem, service providers would treat clients' concerns with overcoming infertility with as much care as clients' concerns with avoiding unwanted or closely spaced births. Providers would also recognize that in conditions of economic crisis, women's perceived need for family planning may rank below

other needs. In an income-generating and consciousness-raising association of about 7,000 destitute rural women organized in 400 groups in Bangladesh, for example, women who were asked about their objectives in joining the groups generally ranked "to receive family planning" below other goals such as "obtain redress from moneylenders," "stop the dowry system," "send children to schools," "get correct and fair wages," "encourage group savings," and "rescue from torture of husbands" (Banchte Shekha 1986).

Childbearing and fertility regulation among vulnerable groups occur within an environment of social and economic risk and uncertainty (e.g., Schnaiberg and Reed 1974; Cain 1981). Service providers must be acutely aware of the risks as well as the benefits to women of spacing or limiting births or of using a contraceptive method (see chapter 6). Women may fear divorce, abandonment, physical abuse, or social rejection if their contraceptive practice is known, for example, or experience anxiety about method side effects that could alter menstrual patterns or cause subsequent fertility impairments. The more rigid is the patriarchal system enforcing female economic dependency, the greater is the risk to women of restricting their childbearing or of going against their husband's or elders' wishes. The risk is especially severe where labor markets that might otherwise provide some independent economic security for women are most discriminatory.

2. *Empowering women to overcome their oppression*

A reproductive health program forms one component of a comprehensive effort to transform power relations in the family, the community, and the society. It challenges female subordination in the sexual and reproductive spheres as well as in other spheres of women's lives. Reproductive health is related both ideologically and programmatically to these broader human rights goals; indeed, it is subsumed by them.

The essence of a feminist reproductive health program is empowering clients as individuals and in groups, however poor, *to make demands* of themselves, their families, and their communities. In many cases the first step is the most difficult: to encourage women to "break their silence" about their sexual and reproductive problems and their experience with health systems. In Nigeria, for example, sociologist Mere Kisekka (1989c:2) points out that women have "internalised the ethic of 'nobility in suffering' such that pain and discomforts emanating from their reproductive and sexual roles are accepted as the very essence of womanhood. . . . [S]ocial stigma, and hence the culture of silence, [is] attached to sexual and reproductive problems, the geneses of which are invariably perceived to be women." The culture of silence characteristic of many societies translates into a reluctance among some women to press for their personal

rights even in clinic settings. "Their desire to have their human rights observed is not expressed as an 'entitlement,' " writes one observer, "but rather as a wish for dignified and fair treatment" (Bruce 1987:378).

A feminist reproductive health program means empowering clients to make demands on public and private agencies and individual providers for the type of care they want. It means empowering clients to make demands on their sexual partners for respect and cooperation in sexual relations, fertility regulation, and childbearing and rearing. It also means creating conditions by which women can act unilaterally to control their own fertility, if they wish, through the use of non-detectable contraceptive methods and of tubal ligation or abortion on an outpatient basis. In the words of British historians J. A. and Olive Banks cited earlier in this book (1964:125), a feminist agenda "involves a campaign waged in the face of opposition—a struggle of the underprivileged female against the dominant, privileged male." It may also involve race, caste, and class struggle, with particular emphasis on empowering women in oppressed groups to act on their own behalf.

3. *Offering an appropriate array of reproductive health services*

Designed to meet the needs of girls and women of all ages and economic conditions, the reproductive health concept incorporates a holistic approach to prevention and treatment that centers on the person rather than on a particular part or function of the physical body.

Ideally, a reproductive health program would include (1) education and counseling on sexuality, contraception, abortion, childbearing, hygiene, infection, and disease; (2) screening and treatment of reproductive tract infections (including sexually transmitted diseases), cervical cancer, and other gynecological problems; (3) informed choice of contraceptive methods, with systematic attention to contraceptive safety; (4) safe early abortion for contraceptive failure or non-use; (5) prevention and treatment of infertility; (6) prenatal care, supervised delivery, and post-partum care; and (7) infant and child health services (Germain and Ordway 1989). Services can be offered directly or through referrals, in both public and private sectors. Offering an array of services in one center or community outreach program can encourage followup and continuity of care. In addition, each new service, such as prenatal care or child immunization, pulls in additional clients who then return for other services, such as contraception.

Service priorities will depend on the perceived needs of client populations and on organizational capacity. The Bangladesh Women's Health Coalition, for example, began in 1980 as a single-purpose clinic offering safe, legal menstrual regulation for low-income women (Kay, Germain and Bangser 1991). It added contraceptive services and counseling almost

immediately. As the organizational capacity and number of clinics grew, the coalition responded to clients' demands for additional services by adding primary maternal and child health care such as immunization, nutrition education, and referrals for high-risk pregnancy, and a birthing center in one clinic. In the late 1980s the coalition initiated (on a small scale) diagnosis and treatment of common reproductive tract infections which contribute to infertility and other disabilities. Other groups have other concerns. Latin American feminist health collectives have placed a high priority on sexuality and rape counseling, safe abortion services or referrals, dealing with violence against women, and ensuring contraceptive safety and choice, including protection from unsafe biomedical experimentation. A group of Nigerian health activists has identified infertility as a major focus of its immediate concerns (chapter 4), which encompasses the prevention and treatment of infections and other damage caused by unsafe abortion, unsafe delivery, unsafe sexual practices, and customs such as female circumcision. An appropriate constellation of reproductive health services would be responsive to the specific concerns and requirements of diverse populations. Each of the elements of reproductive health is phrased as a social entitlement which forms the foundation of reproductive choice and freedom.

4. *Ensuring informed choice of birth control methods*

A feminist perspective on reproductive health values a broad range of method choice in fertility regulation, including a woman's right to use a less effective method, to use a method only sporadically, to switch freely from one method to another, or to refuse any or all services or products. These options follow logically from the principles of informed choice and self-determination. Every woman will weigh differently from every other woman the relative risks and benefits of each method of birth control and of childbearing at different points in her life (e.g., see Hass 1976; Bruce 1987). Once she is made fully aware of the available options in contraception, sterilization, and abortion through intensive counseling on the risks and benefits of each method—whether male and female methods, natural or artificial—the individual woman is in the best position to know what is right for her.

Unlike the conventional family planning program that urges adoption of long-acting methods such as the IUD, implants, or male or female sterilization, a feminist program would support trial use and method switching. It would also place more reliance on barrier methods such as condoms, diaphragms, cervical caps, sponges, or spermicides, some of which help prevent sexually transmitted diseases. Providers could offer instruction in coitus interruptus (withdrawal), "natural family planning"

(periodic abstinence), and breastfeeding as spacing mechanisms for women who are willing to accept a higher risk of pregnancy, or where safe abortion is readily available in cases of method failure.

Concerns about contraceptive choice and safety have posed a dilemma for feminists, just as they have for governments, researchers, program administrators, service providers, and clients themselves. Should a woman be offered methods that may produce or exacerbate other health problems or even cause death, no matter how small the probability? How does one balance the principles of individual freedom and social entitlement in this case? The vehement opposition of some feminist health advocates to the use of hormonal injectables and implants under any conditions is one example of such controversy. Yet, others contend that women should have access to the full range of available methods under conditions of fully informed consent, careful screening for contraindications, and adequate medical followup. These preconditions are, of course, very difficult to meet. Counseling, screening, and followup are inadequate in most developing countries, especially in rural areas, and among some subpopulations in industrialized countries as well.

The challenge of a reproductive health program is to ensure that adequate monitoring is possible within the context of individual choice. There is probably no drug or device or medical procedure without risk. In this sense, the need for client education about possible side effects and informed consent is not unique to family planning. Women should have the freedom to choose, but they are also entitled to protective legislation that regulates the conditions under which drugs, devices, or medical procedures can be tested or marketed and to participate in this legislative process so that their own views are heard.

The right to safe and low-cost or free abortion on request lies at the heart of method choice. Abortion represents a woman's ultimate veto power over an unwanted or mistimed pregnancy—that is, over coerced childbearing—as well as an essential reproductive health service. Abortion will always be necessary as a backup for contraceptive failure or nonuse where women or couples are determined to prevent an unwanted birth. In addition, many women prefer abortion to contraception because it meets their particular needs at a given time better than contraception does. Where abortion is properly performed within the first 12 weeks of pregnancy, the resulting mortality rate is lower than for other family planning methods such as the IUD, tubal ligation, or hormonal pills. The availability of safe, supportive abortion services as a basic component of women's comprehensive reproductive health care is thus neither an unfortunate fact nor a necessary evil, but, like all family planning, is a woman's right, a social entitlement, and a positive social good (Petchesky 1984:387).

5. *Expanding choices among delivery systems and providers*

The concept of choice extends to individual providers and institutional delivery systems. Male and female clients from diverse backgrounds will respond differently to providers of various types, often strongly preferring some over others based on their social values and personal experiences. Systems differ in their ideologies, accessibility, cost, physical and social settings, modes of transaction, type of goods and services, technical competence of providers, and familiarity to the client. Mechanisms of service delivery may determine the acceptability of contraceptive methods and other reproductive health services: "The service delivery experience encapsulates the method, and in the clients' minds, is part of the 'technology.' *Women do not choose simply to use a specific method; they choose to accept interaction with an often complex service apparatus*" (Bruce 1987:36; emphasis added).

Channels of service delivery are so varied that it is not possible to assess the potential advantages and disadvantages of each type (Lapham and Simmons 1987:341–542). A comprehensive reproductive health program would include both clinic-based and community-based delivery systems in the public and private sectors. Clinic-based services include free-standing, mobile, or hospital-based clinics run by governments, NGOs, or private for-profit operators as well as the offices of physicians and other medical or paramedical personnel. Community-based services include pharmacies and other retail outlets in the formal sector, street vendors and traditional health practitioners (e.g., herbalists and midwives) in the informal sector, and field-workers in community programs. The latter offer basic health and family planning information and services house-to-house (usually woman-to-woman) or in specialized settings such as factories and other workplaces, festivals and markets, women's clubs, high schools or adult literacy classes, and cooperatives and credit societies. Community field-workers are often outreach workers for clinic-based programs. Some services and supplies can be offered in the client's home or in other non-clinic settings (e.g., condoms, contraceptive foams and suppositories, resupplies of pills, nutrition supplements, prenatal monitoring, and perhaps immunizations and midwifery), while others are usually referred to clinics (e.g., female and male sterilization, abortion, IUD insertion, gynecological problems, high-risk pregnancies).

Patterns of concentration or diversity in the sources of selected family planning and health services—for example, between public and private sources—can be identified in the Demographic and Health Surveys undertaken in a number of developing countries in the mid 1980s. In Brazil, for example, 93 percent of women using the pill obtained their supplies from a pharmacy and only 4 percent from government health facilities and 1 percent from private physicians or clinics. In contrast, only 3 percent

of women in Senegal who used the pill went to pharmacies compared with 43 percent each in government and private health centers. Thai women relied heavily on government facilities (70 percent) and on pharmacies (23 percent) with almost none resorting to private physicians or clinics. Although these comparisons illustrate some apparent distortions in sources of supply, their interpretation requires fuller knowledge of the situation in each country.

By definition, community-based programs are intended to bring essential services closer to clients, especially to low-income and rural households with less access to formal health facilities, and to women. Also by definition, they offer considerably more scope for community participation and entrepreneurial initiative than do clinic-based programs. Community-based services can offer alternatives to formal medical centers, relying instead on more informal contacts between clients and providers, the latter of whom are usually less highly trained and thus socially closer to their clients than are clinical personnel. Moreover, community-based programs in countries with discriminatory labor markets such as Bangladesh have provided important new employment opportunities for thousands of women as health and family planning field-workers (Simmons et al. 1988).

Feminists have supported in principle the diversification of delivery systems as a means of improving access to important reproductive health services among potentially marginalized groups such as teenage girls, ethnic minorities, nonliterate women, or married women who are unable to leave home. Many remain nervous, however, about the implications of distributing contraceptive methods such as the pill in situations where users may not be fully informed about their correct use, contraindications, and possible side effects (International Women's Health Coalition and the Population Council 1986:18; Bruce 1987; Germain 1987). Needed are innovative efforts to educate providers of all types, along with better inserts for contraceptive packaging that can be easily understood by clients with limited reading skills.

6. *Providing counseling and educational programs*

A comprehensive reproductive health program would offer individual and group counseling and educational programs to clinic and community participants on topics such as fertility control and reproductive physiology, male and female sexuality, reproductive health and nutrition, and the elimination of harmful practices such as female circumcision or damaging treatments during pregnancy, childbirth, and the post-partum period.

The need for high quality counseling of individuals and couples in their choice of a birth control method which includes clear information about

possible side effects is increasingly recognized as essential to ensuring informed choice and user satisfaction. It has also raised contraceptive acceptance and voluntary continuation rates in a variety of settings (Gallen and Lettenmaier 1987). Training manuals and techniques have been developed to improve providers' communication skills and the accuracy of their technical information, not only for family planning clinic personnel but also for community outreach workers, pharmacists and shopkeepers, and traditional midwives (ibid.). Less has been done in the realm of male and female sexuality, including counseling on how to achieve more pleasurable sexual relations, how to treat sexual dysfunctions, and how to recognize, treat, and prevent reproductive tract infections and sexually transmitted diseases. (AIDs counseling may represent one exception.) The lack of attention paid to female sexuality concerns feminist health advocates in many countries who are confronted in their everyday work with women who in ignorance of their orgasmic capacities feel "used" by their sexual partners.

The key to good counseling is adaptability to the needs and concerns of each client, couple, and group. Feminist women's health collectives in industrialized and some developing countries have experimented with a variety of individual and group counseling methods that share a strong self-help focus and egalitarian ideology (Ruzek 1978). Some of the more radical-feminist self-help clinics in industrialized countries have appealed to a relatively small minority of women, however—usually young and well educated—who share a feminist ideology of alternative health care (Jones, Thoss, and Scottish Health Education Group 1987). Many women in poverty in both industrialized and developing countries, as well as middle-class women, may prefer a more conventional model of counseling and service delivery. For some women this may include a preference for male physicians, for example, and for *more* rather than less social distance between provider and client as a basis for trust and respect. The feminist principle of learning from the experiences and needs of women in diverse circumstances means that both the content and style of counseling and educational programs would be developed through a participatory process.

7. *Challenging discriminatory attitudes and behavior in the community*

The low status of women has been identified as a root cause of maternal deaths, poor health, and high fertility in many societies (e.g., Starrs 1987). In the light of the broad interpretation of reproductive health and rights proposed here, administrators of family planning and health programs, whether governmental or nongovernmental, would define their missions not only as delivering comprehensive and high quality fertility regulation

and other reproductive health services to all social groups, but also as advocating the elimination of those oppressive institutions and practices that impede girls' and women's knowledge of and access to family planning and health services.

A variety of mechanisms could be created to challenge discriminatory attitudes and practices within the community. These can be tailored to the mass media, to political and religious leaders, to the schools, and to community groups of various kinds. Community-based health and family planning field-workers offer a good resource for reaching individuals and households with positive messages. In Bangladesh, for example, female outreach workers in a rural family planning extension project have served as effective change agents in altering the "calculus of choice" that binds women and men to patriarchal attitudes and practices. Workers try to win the support of husbands and other relatives for family planning while encouraging women to make their own decisions, if necessary, which may include surreptitious method use (Simmons et al. 1988). In addition, locally controlled women's income-generation projects; literacy programs, and grass roots community organizing can all change women's (and men's) consciousness and objective options (Rogow 1986:92). Women's organizations are a key resource in this endeavor.

8. *Building linkages with related programs and providers*

The question of whether family planning programs in developing countries should be integrated with health programs or operated as separate administrative entities has elicited a great deal of controversy over the years. Although complete administrative integration might appear to be both effective and efficient and tends to be favored by the medical profession, some family planning advocates fear that integration would dilute the resources and focus of the family planning effort and force a dependency on health ministries and infrastructures which in many countries are relatively weak. Instead, they say, specialized population activities should remain administratively distinct, although linked in some way to health programs (Simmons and Phillips 1987). Such linkages can include adding selected MCH and primary health care services to family planning programs—and vice versa—to create multiple-service packages in clinic or community settings; operating parallel but coordinated health and family planning programs; or establishing a reproductive health referral system at each specialized service delivery point that identifies sources of other specialized services. Similarly, clinic- or community-based workers can remain specialized in their functions or add other reproductive health tasks and referrals to their current "portfolio."

Evidence is mixed on which strategies are more effective in delivering family planning and health services and in attracting clients. Much de-

pends on organizational capacities, worker motivation, and the quality of care provided. Although there is some preference for multiple-service packages in the same location, the bottom line of this debate for women's health advocates is the extent to which girls and women in diverse settings have access to a culturally acceptable and affordable range of services, whatever the mechanism may be.

9. *Training workers in accountability and quality of care*

The successful delivery of reproductive health care requires services that are accessible, acceptable, and of high quality. *Accessible* services are designed with the client's specific needs and abilities in mind with regard to location, mode of delivery, hours of service, costs, and communication skills. *Acceptable* services are those with which clients feel comfortable and satisfied. *High quality* services depend on providers' technical competence, sensitivity to the needs and concerns of each client, continuity of care, and commitment to fully informed personal choice for all women. These guidelines pose a challenge to professional staff and field-workers in southern and northern countries alike. As Judith Bruce (1987:380) concludes in her analysis of users' perspectives on contraceptive technology and delivery systems, "Service delivery systems rarely transcend the structural limitations characteristic of their societies. More frequently, they reflect these limitations or even extend prevailing discriminatory concepts about women's roles and entitlements. But they, too, can be realigned to be conscious in ideology and design of the needs of their clients." "How do we reach these women?" Bruce asks. "How do we protect their interests, their pride, and their privacy? What fears and limits can we help them overcome?" The most effective way to answer these questions is clearly to listen to the women themselves.

Women's health advocates throughout the world have highlighted the need for better training of health and family planning workers in the philosophy and techniques of listening to and empowering their clients. Training is required at all levels, from program managers through professional medical and nonmedical staff through paramedical and support workers. Although training techniques and content need to be tailored to specific situations, elements of quality of care include ensuring technical competence, conveying information accurately and clearly, raising sensitivity to girls' and women's modesty and fears, managing pain, and emphasizing client satisfaction and continuity of care in both clinic-based and community-based programs (Bruce 1990). Good evaluation research, record-keeping, and accountability procedures are also essential. Moreover, every attempt would be made to minimize the hierarchical, top-down approach to service delivery, including those " . . . class, race, and other differences that distinguish the interests, experiences, and vulner-

ability of women with professional training from those of the women whose fertility they are 'managing' " (Jaquette and Staudt 1985:258). Where possible, program staff such as outreach workers, paramedics, and counselors would be recruited and trained from among the ranks of the women they serve. Interpersonal skills would be as important as technical skills in the selection and training of service providers.

10. *Eliciting commitments from governments, NGOs, and bilateral and multilateral funding agencies*

The reproductive health approach does not require massive infusions of additional funding nor does it replace currrent institutionalized delivery systems. Instead, it pulls together elements of major existing programs as building blocks of a more comprehensive approach to women's reproductive health and rights and identifies directions of change (Germain and Ordway 1989:10).

National and international priorities have shifted during the 1970s and 1980s with respect to major initiatives in Family Planning, Maternal and Child Health (MCH), Primary Health Care, Child Survival, and Safe Motherhood. Each of these initiatives incorporates different objectives, program strategies, and client populations. It should be possible to pull the threads together in a manner that identifies current gaps in reproductive health priorities and service delivery at the national and international levels. Family planning programs, for example, whose primary objectives are to promote contraceptive acceptance and reduce fertility, generally focus their attentions on married women of reproductive age who already have two or three children. They are less oriented to younger or unmarried women, women who want to be pregnant or want to terminate a pregnancy, and women with other reproductive health problems (Germain 1987:5). MCH programs serve pregnant and recently delivered women and their young children; safe motherhood initiatives concentrate on pregnant women through delivery; child survival initiatives serve women only indirectly through their emphasis on the mother's role in infant and child health. Missing from all of these client populations are adolescent girls, infertile women, women with reproductive tract infections, women not currently at risk of pregnancy or bearing children, victims of rape and violence, and others who "fall through the cracks" of service delivery—if services are available at all.

A sustained commitment to women's reproductive health and rights would build on current population and health programming as well as on women in development programming in governments; NGOs such as the International Planned Parenthood Federation with its multiple country affiliates; multilateral donor organizations such as the World Bank, World Health Organization, UNICEF, and the United Nations Population Fund

(UNFPA); and bilateral agencies such as the U.S. Agency for International Development. It would involve the critical analysis and coordination of existing efforts in order to define women's reproductive health—and, as a natural byproduct, the health and well-being of children—as a key element of population, health, and development programming.

THE DEMOGRAPHIC SIGNIFICANCE OF GENDER EQUALITY AND REPRODUCTIVE RIGHTS

There is no doubt that the world is faced with an overwhelming problem of sustained population growth at the global level. Although population growth rates have slowed since the 1960s and 1970s almost everywhere except sub-Saharan Africa, the 1990s will see the greatest increase in human numbers of any decade in history: almost one billion people. The demographic momentum engendered by past and current growth rates carries larger and larger waves of human increase in sheer numbers even as the rate of growth declines. Between 1990 and 2010 the world's population is likely to increase by one-third. The populations of southern countries, if they continue growing at 2 percent annually on average, will double in 34 years. The arguments presented in this final chapter are in no way intended to denigrate the seriousness of the population problem or to suggest that nothing need be done. Rather, they are presented as an alternative to conventional calls for "population control" in southern countries and for the intensified recruitment of family planning "acceptors" as its tool.

Analyses of the impact of population trends on economic growth and environmental degradation are clearly important. But the evidence suggests that many top-down approaches to controlling population growth through political campaigns and massive family planning promotions have been relatively ineffective, or have provoked fear and opposition among major population groups and within families, or both (Warwick 1982; Hernandez 1984). Feminist health advocates have been particularly vocal in their criticisms. At the same time, the multiple reproductive health needs of many girls and women remain largely unmet. In India, for example, where massive sterilization campaigns in the 1970s caused a political uproar and where the birth rate has remained stubbornly high, critics contend that the population program has been too focused on statistical objectives and too interested in quick solutions. Needed is a longer-term, more moderated approach centered on a good system of health delivery at the grassroots level together with improvements in literacy, skill development, income generation, physical and emotional security, and respect for human values (Bose 1988). Indian feminists add, "The new strategy should put family planning in the broadest dimension of social change. . . . It should be . . . a people's movement and a commun-

ity endeavor," not an externally imposed program (Karkal and Pandey 1989:106).

The search for a more responsive reproductive policy described in this chapter has considered both policy process and content. Ideally, the process becomes transformed from one that is externally imposed and technocratic to one that is internally motivated and humanistic. Listening to women's voices in the design and implementation of reproductive policies and programs involves a fundamental reorientation of policy-making processes and priorities. Indeed, it constitutes a shift in paradigm: a different world view, requiring different theories and lines of inqury. Turning things upside down, a woman-centered approach begins by trying to understand the concrete material and social conditions of women's lives in different contexts, and the meanings that women attach to their sexual and reproductive experiences. Programs and policies build on and adapt to these experiences.

The policy content becomes transformed as well. In bringing together the previously separated streams of thought about human rights and population processes, four major shifts occur. First, a development policy becomes a human rights policy designed to ensure that all persons have an adequate standard of living together with other basic freedoms and entitlements that are essential to personal security and reproductive choice. Second, a population (reproductive) policy becomes an equal rights policy designed to eliminate discrimination against girls and women in economic, social, political, and cultural life. Its intent is to undermine those gender-based structures and ideologies that curtail girls' and women's control over valued material and social resources and perpetuate patriarchal pronatalist controls. Consider, for example, the Philippines Development Plan for Women created by the National Commission on Women with input from women's organizations and government ministries as an accompaniment to the Medium-Term Philippines Development Plan for 1989–1992 (see chapter 4). The plan for women contained a broad range of sectoral goals and timetables, as well as particular demographic goals that focused on women's and children's well-being.

Third, a family planning policy becomes a reproductive rights policy designed to ensure that women and men are able to exercise genuine sexual and reproductive choice. Standards are set to protect individuals from coercive efforts by both pronatalist and antinatalist forces at the state, community, and family levels. In Brazil, for example, a national Committee on Reproductive Rights worked closely with the National Council for Women's Rights to formulate guidelines on women's sexual and reproductive rights. In the Philippines, a major umbrella organization for women's associations, GABRIELA, formed a Commission on Health and Reproductive Rights to set policy guidelines. Fourth, a family planning program becomes a reproductive health program designed to extend

a full range of sexual and reproductive health services to women (and men) of all ages, particularly those who are excluded by reason of economic, social, marital, or pregnancy status from current programs. Again, the feminist-sponsored Integrated Women's Health Program in Brazil together with its associated Policy on Women's Health and Family Planning is an important example of this type. Fertility control forms only one (but a key) element of a reproductive health strategy enabling women to understand and enjoy their own sexuality, to regulate their fertility safely and effectively, to bear and raise healthy children, and to remain free of sexual violence and reproductive disability.

Human rights, women's rights, reproductive health: do they constitute a population policy? Yes and no. Their primary aim is *not* fertility decline, but rather, the expansion of human rights and improvement of human welfare. In this sense, then, the interventions do not—together or separately—constitute a population policy in the limited way we have defined it.

Nevertheless, there is little doubt that such interventions are likely to create conditions favorable to lower fertility if they are designed and implemented through a flexible participatory process to meet the needs of specific population groups within each country. A *rights-oriented development strategy* that improves the distribution of incomes and other resources among population subgroups, for example, can alter the environment of reproductive decision making in fundamental ways. In particular, structural changes combined with rising expectations can reduce the dependence of low-income and landless rural populations on children for their security and survival, reorient their survival/security strategies toward long-term investments in children's health and education, and reverse the inter-generational flow of wealth (e.g., Ridker 1976; Murdoch 1980; Caldwell 1982; Bulatao and Lee 1983). An *equal rights strategy* that explicitly challenges those ideological and structural forces that currently deny girls and women genuine choice can have a demographic impact by altering the circumstances of female dependency, marriage and divorce, schooling and employment, property ownership, inheritance and legal rights, and women's abilities to mobilize politically (United Nations 1975; Cochrane 1979; Bulatao and Lee 1983). A *reproductive rights policy* would remove legal and other impediments to the use of contraception, voluntary sterilization, and abortion, while prohibiting early arranged marriages, encouraging male financial responsibility for the children they father, and facilitating divorce. Each of these interventions is likely to reduce fertility. Finally, each of the ten elements outlined for the *core program in reproductive health* will, arguably, favor lower fertility by altering the conditions of sexual and reproductive decision making and providing services that encourage more sustained contraceptive use (e.g., Jain 1989). These elements consist of designing programs based on women's experiences,

empowering women to overcome their oppression, offering an appropriate array of reproductive health services, ensuring informed choice among a range of birth control methods, expanding the channels of service delivery, providing counseling and educational programs, challenging discriminatory attitudes and behavior in the community, building linkages with related reproductive health programs and providers, and eliciting commitments from governments, NGOs, and international funding agencies.

If women are to control their own reproduction safely and effectively, they must also be able to manage their own health and sexuality, to achieve social status and dignity, and to exercise their basic economic and social rights in the family and in society. A population (reproductive) policy cannot be considered apart from an equal rights policy. Redefining the content of a population policy in this way should help to pull together different segments of activists working in northern and southern countries on issues of human rights, women's rights, and reproductive freedom. Most important, ridding family planning of its population control rationale and substituting a broader reproductive rights and health focus should appeal to the population, health, and family planning communities, on the one hand, and to feminist health advocates and human rights activists, on the other. The joining together of these communities in a common endeavor becomes all the more compelling in the context of a global political environment in which threats to women's rights and reproductive freedom are becoming more powerful. Women's rights groups and the population/family planning establishment cannot afford to be divided in their purpose, nor can feminists allow their anti-family planning rhetoric to be coopted by "right-to-life" organizations committed to the abolition of all artificial methods of birth control and to the perpetuation of women's subordination.

SECTION II

"RETHINKING POPULATION POLICY"

Imrana Qadeer

The debate on population size and growth is old and has been enriched by thinkers of various hues. It originated between two opposing ideological perspectives on growth of population. One, considering it a primarily natural phenomenon, and the other, an outcome of the social nature of human organizations. Both have contributed to knowledge in such a way that today almost everyone is agreed on some basic concepts.

POPULATION IN THE REALM OF THEORY

Population growth is no more seen as an independent variable affecting development. It is the outcome of a complex process of socio-political and economic interactions. It also affects development differently in different socio-economic conditions. History has demonstrated that high population growth rates are not necessarily associated with poverty. Population experts today are questioning theories based on assumptions such as economic performance and progress depend critically on resources per head; income per head is a measure of wellbeing; and that population forecasts for decades ahead can be reliable. In other words, the dominant concept of development as a purely economic entity is itself being questioned.

The experts are arguing that the most critical factors in development are transfer of productive techniques, social, political and legal institutions, and knowledge, and not population growth. There are others who point out that the less developed countries (LDCs) have already moved more than half way towards a birth rate that yields zero population growth. Till 1970 women in these countries were bearing 6.1 children and the number now is 4.1.

Even the proponents of doomsday have extended their analysis of the global issues. Retaining their concern about population explosion in LDCs, they now add factors such as: the over consumption of resources, the fast degrading environment, and high energy use in the West, the magnitude of military resource expenditure and benefits derived from it by industrialized economies, and the co-existence of food gluts and famine.

The focus of the debate thus has shifted to the relative influence that population growth exerts in the process of development. Theoretically, population is no more the all or non-important factor in dealing with the problem of under development and poverty. It is said today that the rapid population growth in most times and places is a relatively minor factor in reducing per capita income. Even then, population may be easier and "cheaper to manipulate" than other influences on development.

GLOBAL PRACTICE AND POLITICS

The crux of the matter then revolves around questions such as the cost of Family Planning Programmes (FPP) and the way these costs are defined, why these programmes are considered "cheaper" and for whom? why the developed world is ready to transfer its reproductive control technologies but not its productive techniques, and why the LDCs wish to have aid and access to markets but are not willing to alter some features of their social, legal and political organizations?

These issues are obviously political in nature. At different levels, different social configurations are at conflict. The dominant sections of the DCs are ready to critique their own system and change to some extent but are not ready to see the links between the patterns of growth in the two halves of the world. They are ready to interfere in other countries affairs in the name of `Saving democracy' but are not ready to recognize their own role in the undermining of democracies in these countries. Not very different in behavior are the elite of the LDCs who resist change in their own social and legal structures, largely remain silent on issues of economic self-reliance and the artificial economic boundaries created by the developed nations, but if necessary, would have no hesitation in taking away the gains made by the poor in their own country.

In this prevailing political scenario, characterized by the self-interest of the dominant classes, mere recognition of the not-so-critical role played by population numbers remains only in the realm of theory. In practice, the growing population of LDCs is seen to be a serious threat to the privileges acquired by DCs. The former attempt to appease and to adjust, invariably at the cost of their own less-privileged.

For the elite of both the halves then, population control becomes a key factor in their own development. Not necessarily because this is a panacea for poverty but perhaps because it is the best way to contain the unmanageable load on their consciences. At one level, the victims are the people of the LDCs, a big chunk of whom are seen as dispensable, and at another level, it is the poor within the LDCs who are seen as the indiscriminate breeders.

NATIONAL LEVEL EFFORTS

Historically, both control of numbers as well as women's health and rights have been the inspiration for the contraceptive movement. India's FPP has focused on the control of numbers either explicitly or under the cover of family welfare. Its strategies were influenced by the lessons of practical experience and the political demand of controlling numbers in a short span of time. The mass camps of the late 60s and the forced sterilizations during the Emergency were the two points in history where it became openly and aggressively Malthusian and followed the dictates of the hawks in Family Planning. The consequences continued to affect the programme negatively for a long time while the strategies vacillated between genuine, and not-so-genuine efforts at integrating the FPP with developmental efforts.

An integrated package of Family Planning, Nutrition and Maternal and Child Health (MCH) was introduced by the Fifth Five Year Plan. This, however, did little to improve nutritional status or health of even the vulnerable groups. These services became appendages of the FPP and were primarily used to increase its acceptance. The stagnation of IMR and Nutritional status over the seventies are evidence of this tragedy.

At the end of the Fifth Five Year Plan the problem was realized by the National Group on Population. It argued for an integrated approach which, by providing all basic services, creates demand for family planning rather than using them as a bribe. This strategy could succeed only if Nutrition Programmes were accompanied by long term solutions to food availability and access. The Working Group however, was planning within a set of political constraints and could not go beyond the limits of Minimum Needs Programmes (MNP). The Group's strategies to help women also operated within the domain of MNP and "maternal health". It left aside all other issues of women's health and at best pushed them into the unorganized sector without giving them any real assets. A set of relevant strategies therefore, could not really take off as they were contrary to the requirements of the politically accepted notion of general development.

It is interesting that despite national expenditure on FPP going up from 0.5% to 24.7% of the health budget, the couple protection rate continued to fall short of targets till 1990 when it reached 41.9%. Seen against the backdrop of the technical problem of calculating achievements and coverage of demographically ineffective couples, these achievements get further diluted. This forced the political leadership to accept the futility of carrying on an official, government - sponsored programme without the support of people. It conceded the necessity of a holistic developmental approach to family planning.

LESSONS FROM PRACTICE

In the process of reassessment over the 70s and 80s many lessons were learnt. A number of studies showed that acceptance of family planning was based on different levels of motivation. Each level in turn required different kinds of inputs.

For example, the high infant and child mortality was recognized as inhibiting acceptance of small family norms. The health of mothers was understood to be critical in postpartum acceptance of contraception as well as in its regular use. Thus at one level, improvement in health services which could contribute to a reduction of the load of morbidity and mortality among women and children, was seen as necessary. At another level, studies revealed a strong corelation between education and socio-economic status of women and acceptance of family planning, revealing the transforming potential of these inputs for participation in decision-making. These help them to see beyond their reproductive roles, thus enhancing their acceptance of family planning.

At a third level, it was agreed that in a traditional agrarian society where the proportion of self-sufficient peasants is high, the need for family labour determines the basic family unit size which is generally higher. Only when the structure of agriculture changes and the self-sufficient peasant units yield to rich farmers and landless labourers, is the labour demand sufficiently altered to affect the desired number of basic family size. This differential too was recognized.

In other words decline in infant and child mortality through improved health services and environment, improved status of women and transformation of agrarian structure were accepted as some basic prerequisites for family planning. These called for a re-evaluation of the developmental strategies.

Experience of FPP thus showed that for the sake of population itself, it was necessary to deal with a complexity that went beyond reproductive technologies and demographic targets. A narrow vision led to a waste of resources and failures. It was also apparent that political constraints did not permit interventions other than those that were technological or managerial. Caught in its contradiction, the programme experimented with short term narrow strategies over the 80s that often became self defeating. Some of these are discussed here.

INTEGRATION OF THE FAMILY PLANNING PROGRAMME

The dismantling of single purpose institutions of family planning - the Regional Family Planning Training Centre, the Urban Family Planning Bureaus and the mobile district IUD team - was followed by their integration with the General Health Services. However, Family Planning continued to receive singular priority. The result was that now, instead of FPP structure alone, the entire structure of the health services was geared to achieve the targets. It received a further bonanza when the 6th and 7th Five Year Plans went in for the expansion of rural infrastructural facilities. Expansion of health services was actually accompanied by a decline in the proportion of funds going to the main public health problem i.e. communicable diseases. Even in the 8th Five Year Plan, Rs.547.6 crores and Rs.759.4 crores were spent on Health and Family Planning in the year 1991-92. In 1992-93 these expenditures were Rs.560.3 crores and Rs.1010.4 crores respectively. The much acclaimed increase in the health budget reflected the heavy pouring of resources into AIDS control programmes, for which the World Bank earmarked Rs.58 crores. Thus integration, instead of leading to multiple services, infact became the means of exploitation of other programmes. FPP snatched their resources and humanpower and enhanced its own drive for targets.

What this strategy failed to acknowledge was the fact that weaker public health services contributed to an increased load of morbidity and a concomitant fear of infant death. This by itself becomes a reason for non-acceptance of Family Planning.

REVISED STRATEGY FOR FAMILY PLANNING

Amidst an ongoing frenzy to meet Family Planning targets, yet another shift in strategy was announced in 1986. There was little `new' in it except for a reiteration of objectives proposed by many previous committees of: increasing age of marriage, strengthening health services, improving child survival and safe motherhood programmes, inter and intra sectoral coordination, improved management, relevant socio-economic interventions, promoting population education, and research in better contraceptives.

Of these the maximum attention was paid to the promise of improved management. The bureaucrats and professional managers thus became the key figures in streamlining FPP. Child-spacing through the use of hormonal contraceptives and MCH services became the mainstay of the new strategy. MCH was awarded the privilege of seeking targets while the relevant socio-economic intervention and health aspects of family planning got relegated to the background. Women and Children became the focus of technological interventions.

FOCUS ON CHILDREN

As a part of the integration drive of the seventies the Integrated Child Development Services (ICDS) Programme emerged in 1975 and attempted to provide nutritional, educational, medical and social services to the vulnerable. While the programme was still struggling with its own inner contradictions of double control, conflicts between Programme Officer and Medical Officers, inefficiency and inadequate coverage, the emphasis shifted. UNICEF's child survival strategy of 1983, despite a multipronged approach, became the basis for pushing a vertical immunization programme. (An evaluation of this programme reveals that neither is there adequate data to epidemiologically justify the programme nor is there adequate coverage of children to justify the programme).

Again we see that even the concern for child health was correct, first the child was treated in isolation from its family. Then, choices were made for the family even in the kind of services the child was to receive. The justification of this choice remained technological feasibility rather than real needs of the majority of children who became vehicles for the FPP.

FOCUS ON WOMEN

Programmes promoting womens' welfare lagged behind as they got caught in the conflict between welfare and economic adjustment. The FPP's experiment with popularizing vasectomies was brief. It soon revived its focus on women, excluded their ill health and dealt with their reproductive capacity. The logic behind the approach is stated to be the greater extent of suffering borne by women as a consequence of frequent pregnancies and births. It is also argued that the ill effects of currently introduced hormonal contraceptives (HCs) are likely to be much less than the negative impact of numerous pregnancies.

The HCs considered for extensive use are Depot medroxprogesterone (DMPA), NET-EN and Norplant. Of these, currently Norplant is the most favoured and has been claimed as safe, reversible and long-acting. There are problems with these assumptions and they need to be examined.

Brushing aside side effects by saying they are less problematic than complications of pregnancy itself has some basic problems:

i) Assuming safety of new HCs on the basis that MMR is much higher than the possible mortality due to HCs is premature for two reasons. Firstly, the limited data on HCs trial precludes a thorough understanding of comparison treats lightly the side effects reported by the trials.

ii) International trials of Norplant report high prevalence of menstrual problems and side effects such as headaches, skin reactions, weight gain, depression, mood changes and dizziness. These are labeled as minor problems. These side effects in fact assume a serious dimension in the Indian context where women are known to have a high prevalence of conditions such as anemia, reproductive tract infections and irregular menstruation, where HCs are contraindicated. Norplant used on a large scale here may cause serious complications.

iii) The pre-introduction trials in 46 countries were conducted largely in the urban centres where side effects could be tackled. In India where emergency maternal care and follow up services are weak, the implications are obvious.

iv) The limited data from India already indicates that the number of users experiencing complications is going to be high. 40% women under ICMR trials of Norplant 2 discontinued use after 36 months due to menstrual problems while 10% women were lost to follow up. Once the trail was stopped none of the 1466 women under trail were followed up.

v) Anthropological data shows that events that effect women's daily routines can seriously influence acceptance patterns. This is particularly true of menstrual disturbances which create special problems in carrying out her functions - domestic, religious and social - particularly in the LDCs where traditional social norms prevail. The so-called minor problems and all types of menstrual problems brought on by HCs can have far reaching consequences for acceptance.

vi) The Population Council trials for developing the Norplant system used IUD users as controls. Problems like bleeding, rejection and infections are very high in the case of IUD. Therefore, when in comparison to IUD, Norplant is projected as safe, it does not say very much.

Despite all these problems the official experts have justified the use of Norplant. Bleeding due to Norplant is said to pose no risk to health. "In fact implant reduces the risk of anemia by overall reduction in blood loss". In other words, for Indian women it is better to have amenorrhoea as a protection for anemia and Norplant offers an advantage rather than a risk! It is also argued that in the LDCs, irrespective of the medical infrastructure, the women can take hormonal contraceptives (oral pills) as, "For those few women for whom they are contraindicated, pregnancy or illegal abortion is even more dangerous".

This choice to `protect' "some" women at the cost of "others", may appear statistically rational, but it neglects the fact that the vulnerable women will definitely have more complications. Their suffering can become a cause for rejection of HCs by other women in the community. This was the case when IUD - induced bleeding became the source of rumours and rejection of IUD in the villages.

The so called `protection' of the majority from the dangers of pregnancy may actually be an added danger for women users who have poor access to health services and higher prevalence of conditions in which HC are contraindicated. Even the post-introduction trials of Norplant in 100 medical colleges covering 20,000 women are not sufficient

for they do not test HC in the rural setting where they are ultimately to be delivered.

These lessons could have been easily learnt from the experience of IUDs inclusion in FPP. In 1965 IUD was provided on an extensive scale immediately after some pilot studies in urban centres and city populations. In the rural areas its acceptance declined within five years of introduction because of the serious nature of complications and lack of infrastructure to take care of users.

Though hormonal contraceptives are being pushed in the name of a woman's right to have more choices, it is clear that she has no role in the making of these choices. The funding agencies are calling the shots and setting directions of research. Thus, while traditional and barrier methods - that contributed to the demographic transition in the West - have been neglected, HCs have been patronized. The Population Council has spent 20 million dollars to develop and introduce Norplant.

Women are thus denied the chance of using a really safe and user controlled contraceptive because research funds are diverted to find surer, though not safer, contraceptives which are provider-controlled and which make women dependent.

FOCUS ON VOLUNTARY SECTOR

The latest strategy of funding voluntary agencies to open operation theaters to provide sterilization, IUD and spacing services, is yet another attempt to avoid confronting the challenge of enhancing informed choices, providing safe contraceptives; and integrated services specially for rural areas and slums. By shifting responsibility this strategy raises a host of questions. Can the government actually prevent diversion of these resources into private practice? Can the inadequacy of Primary Health Centres be made up by opening sterilization wards? Where will these resources come from? and what is the logic of investing in independent institutions at the cost of PHC network? The official documents are silent on these questions.

This review shows that only the initial failure of the FPP led to some efforts at integration in the early seventies. However, the primacy of this programme was never questioned. The post-emergency shock led to withdrawal but very soon better techniques of force were discovered to push for targets. Thus, whatever the strategy choices, the

tactics of dangerous but more definite methods, inadequate information, and tagging fertility control to a variety of health programmes became common and when nothing worked, independent agencies are now being tapped to bail out the programme.

At one end of the socioeconomic system lies the political imperative of the privilege which recognizes the theoretical linkages between development and population, but continues to push in practice at the level of technique. At the other end lies the growing need of the people for non-invasive, humane, and women-empowering methods of birth control. The equation of power between the two transforms family planning from potentially liberating to a humiliating force. Its time we learnt from the experience of the past for population control the issue is not of choices between the two approaches. There is only one way to - the humane way to success.

WOMEN AND THE POLITICS OF POPULATION AND DEVELOPMENT IN INDIA

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Introduction:

After remaining relatively low-key for more than a decade, the `population problem' in India is making headlines once again in the nineties. The popular media is replete with predictions of doom:

`..the runaway birth rate has sent the nation staggering...

We add 45,000 children a day to our population, which is well above the danger mark... In the next 35 years the population will double... This will be double the demand on the basic necessities of life. Food will become scarce; so too, drinking water. And jobs. There will be pressure on land, traffic systems will become clogged, hospitals crowded... The spiraling growth will play havoc with the environment leading to an ecological crisis.'[1]

This despondency with respect to India's population growth has been fueled by the severe economic crisis facing the country since mid-1991. During the 1980s India's gross national product (GNP) grew at a rate of 5 per cent, which was higher than for earlier decades. Increases in crop yields were higher than ever before.[2] Yet growing unemployment, rising prices and pervasive poverty followed.[2,3] The High rate of population growth seemed to be the plausible explanation for this dismal scenario. According to the census of 1991, 159 million people[3] have been added to the country's population in only ten years.

The fact that, even after more than 40 years of state-sponsored family planning programmes, population increases have not been contained sufficiently, has caused panic. For the first time since the mid-70s, When India's population control programme gained notoriety for its coercive excesses, the government has stepped up pressure to make the programme more `effective'. The search is on to evolve a policy package that will lower the `runaway' birth rate without any further delay, there being no time to lose.

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Few people question the need to re-introduce stringent population reduction measures, because of two assumptions:

* Population growth in India has nullified much of the efforts of development, and is one of the key factors precipitating the current economic crisis, and
* The most effective policy option available to the state to deal with the alarming rate of population growth is intensification of state-sponsored population reduction measures, viz. family planning programme, backed up by a package of incentives and disincentives.

This paper questions the validity of these two assumptions, and analyses the Indian government's current policies from the point of view of their effect on Indian women. It shows that these policies, which in theory are meant to support development and solve the country's economic problems, in practice do not. Further, it shows why these policies have failed women in the past and will continue to fail them in the future. Finally, it puts forth alternatives for population and development policy and family planning services, as an integrated programme that would meet women's needs and achieve the government's state aims at the same time.

Economic Crisis: Faulty Development Model Vs. Population Growth Rate

The attention given to population growth as a major cause of India's economic problems has ignored the extent to which the model of development India adopted after Independence is responsible for its several economic crises.

When India gained political independence in 1947, it was among the poorest countries in the world, economically dependent mainly on a stagnant agricultural sector. Social indicators were abysmal: 85 per cent of the country's population was illiterate, life expectancy was only 32 years, serious infectious diseases like cholera, malaria and tuberculosis were widespread and nearly 40 per cent of the population lived below the subsistence level.[4] Moreover, the society was deeply divided by caste, and gender - based discrimination was the norm. Land and other resources were concentrated in the hands of a small elite.

The skewed distribution of resources, with a heavy concentration at the top, meant that for the living standards of the poorest groups to improve appreciably, the economy had to grow rapidly. Alternatively, a radical reorganisation of society was required to make ownership and control of resources much more equitable. This latter option was never given serious consideration since it was against the interests of the ruling elite. Therefore, increased production became the central goal, and was supported by the state in the form of subsidies, credit, and a market protected from external competition. The state's commitment to protecting the poor was expressed through legislation for affirmative action, welfare measures in favour of socially deprived groups, and investment in social services such as public health and primary education, which were to be provided free of cost.

The overall trend for the period from 1951 to 1981, notwithstanding brief periods of acute crisis, was one of modest increase in agricultural and industrial production and in per capita GNP. It is particularly noteworthy that the rate of growth in food production, above 2.5 per cent per annum during most of the period, managed to keep ahead of or at least a pace with the rate of population growth, which ranged from 2 to 2.25, a modest rate in comparison with the majority of developing countries.[2,5]

However, the population was already 361 million in 1951; the net addition in numbers per year rose from 7 million in the 1950s to 12 million in the 1970s. Although economic growth was adequate, it was not rapid enough to meet both the needs of a growing population and bridge the already wide resource gap between the rich and the poor. As a result, about 4 million were being added every year to the ranks of the poor. The proportion of the population below the poverty line remained practically unchanged.[4]

Implementing its chosen economic policy proved to be a major strain on the government's resources. In combination with the costs of unexpected events such as wars and monsoons, an acute economic crisis was precipitated in 1966.

The current economic crisis may be seen as the culmination of the path of `high growth with inequality' which was adopted as a way out of the economic crisis of 1966. During the early 1970s, the government's financial position was considerably weakened by the crisis. There was not enough money for public investment. Consequently, overall economic growth threatened to slow down. At the same time, the resource position of the top sector of the economy continued to be good. Increasing taxes on this rich sector was not politically advisable, while raising additional revenue from the poor was impossible. Pushed into a corner, the government decided to gradually discard its gestures at poverty alleviation, and to switch instead to a different kind of economic policy, in which the economy was `opened up'.

From the beginning of the 1980s, various controls on imports and exports, that had previously helped to avoid external commercial borrowing and keep the country free of debt burden, were relaxed. This was intended to stimulate the purchasing power of the rich who, although a small proportion of the population, numbered more than fifty million. A regime of growth, led by an increased demand for goods by the rich, ensured.
As a result, the composition of industrial production shifted in favour of luxury goods.[6] Salaries and incomes of the top ten percent grew, and in addition, credit facilities for hire purchase were expanded to create, for the first time in India, a `consumer boom'.

However, there was a price to be paid. Imports of consumer goods grew phenomenally. Even locally manufactured goods were heavily dependent on imported components and/or raw materials, which needed foreign exchange.[7] The country's external debt grew

rapidly. Bilateral or multilateral loans could not be raised at favourable terms. Commercial borrowing at high interest rates grew from about a tenth of all borrowing in 1980 to more than a third in 1990. Interest paid on foreign debt increased from 9.1 per cent of export earnings in 1980-81 to 26.3 per cent in 1990-91.[7]

The political instability of 1989-90 made the minority government then in power unwilling to risk any harsh economic decisions. The insurgency movement in eastern India led to faltering domestic production of crude oil. Then the Gulf crisis greatly inflated the import bill for petroleum. These precipitated the current economic crisis. The government found itself unable to pay back loans and interests which fell due in October 1991, and commercial credit was not available. The government approached the International Monetary Fund (IMF) for a loan to pay these back, which was approved in September 1991. However, the country had only earned breathing space, swapping short-term, high interest loans for long-term credit from the IMF.

It is important to point out that during the 1980s, the economy was apparently booming. GNP was growing faster than ever before, at 5.9 per cent per annum. Due to a doubling of yields, growth in agricultural production reached a new high of 3.4 per cent despite there being no increase in land area under cultivation.[2] Population growth had slowed down, declining from 2.2 per cent in the previous decade to 2.1 per cent, implying an increase in food production in per capita terms.[3] Yet this was the period of maximum inflation since Independence. Food prices more than doubled, and so did general price levels.[2] Economic growth did not create any additional employment opportunities between 1981 and 1991.[3]

In other words, rapid population growth alone cannot be blamed for the current crisis. The current crisis was logical given the 'development' path pursued. More crises would follow, affecting health and social services expenditure.[8] These have all hindered favourable conditions for women to practice family planning.

Effects on Women: Some indicators

Women are among the worst affected by the crisis-ridden development path adopted by the country. After four decades of development efforts, gender gaps in access to education and employment have persisted, and are closing extremely slowly. Even today, more than two thirds of the female population is illiterate, as compared to only one-third of the male population.[3] Only about a third of girls over age 11 have had six years or more of schooling, and only about a tenth complete 11 years of schoolong as compared to 67 percent and 23 per cent for boys.[9]

Although participation of women in the labour force has increased in the past two decades, this is believed to be the result of deteriorating economic conditions among the poorest sectors of

the peasantry, compelling women in these households to engage in wage labour. This is evidenced in declining proportions of cultivators and increasing proportions of wage laborers in agriculture with every census.

Ninety per cent of women engaged in so-called economically productive work are casual workers who do not have any security of employment or access to social support. Women's wages for casual work are generally one-half or less than those for men.[10].

Another fall-out of the `growth with inequality' strategy is the escalating social (caste and communal) violence in general, and violence against women in particular.

But by far the most telling indicators of the neglect of women in development planning are related to women's health status and health services for women. India is among the few countries where female mortality from infancy to nine years of age exceeds that of males. Studies probing into the causes of this unusual phenomenon report discrimination against girl children in feeding, care during illness and preventive health care as probable reasons. Even during the 1980s, when the Indian economy was growing fast, the gap in mortality rates remained absolutely unchanged.[11] Worse still, it was during this decade that the practice of abortion of female fetuses, following amniocentesis for sex determination during pregnancy, became widespread in urban centres, and numerous instances of female infanticide in some regions were reported by the press.

Maternal mortality in India is among the highest in the world, at more than 600 maternal deaths per 100,000 live births. (Comparable figures for countries in Western Europe are well below 10). One important reason for this is the lack of trained attendance during birth. As recently as 1988, 66 per cent of rural women and 58 per cent of women overall did not have access to trained medical care during delivery. Only 15 per cent of rural women delivered in any kind of health facility at all.[11]

Poor access to resources, compounded by repeated pregnancies and inadequate health care, has given rise to very high reproductive morbidity rates in women. In a recent study in rural Maharashtra, 92 per cent of 650 women examined medically suffered from at least one gynecological disease, with an average of two per women.[12]

High fertility contributes significantly to high rates of maternal mortality and morbidity. The average number of live children of women currently in the reproductive age group is still greater than four.[11] Given that a significant proportion of pregnancies do not end in a live birth, this means five pregnancies or more per woman.

Clearly, India's development model has failed to create social conditions that favour fertility decline. There are at least 250 million people who lead a hand-to-mouth existence, and whose only

hope of security in old age is children who survive to adulthood. Child survival rates rank among the worst globally, with ten per cent of babies born in rural areas dying in infancy, and a third dying before the age of five. Women's status is low. With limited access to resources and living in the shadow of a patriarchal society, women have no right of decision-making in most areas of their lives. All these factors in combination maintain formidable barriers to fertility decline. Women have no option but to go through many pregnancies to the great detriment of their health.

The present economic crisis makes these hurdles more formidable. The increasing cost of food will directly affect infant nutritional status and survival. Distress-led job seeking, with no social support for childcare, will compromise child health status as well. In the face of increasing prices and insecure jobs, women will need additional hands to share the increasing economic burden. These and the worsening child survival prospects will constrain women from opting for fewer children.

In these circumstances the justification for the government's past and current population policy needs to be questioned.

Population Policy: Women as Culprits

The Indian government adopted a policy of reducing the birth rate as its way of dealing with the economic crisis of 1966. This was, of course, hardly an adequate solution. What it did, however, was to transform the problem of high fertility - of which women and children were the victims - into the problem of 'women having too many children' - of which women were the perpetrators. Today, the government is set on the same path to deal with the current crisis.

During the 1966 crisis, there was external pressure on India, namely from the World Bank, to step up efforts at fertility reduction as part of the agreement to overhaul India's then economic policies. Population was the second of eleven areas for which specific policy directives and targets were adopted.[13] In order to hasten the pace of fertility reduction, the existing family planning programme was transformed in 1966 from one that provided services to those who requested them, into a population reduction programme with specific demographic goals.[14]

The target of reducing the crude birth rate from 39 to 32 per 1000 by 1974 was set. This was translated into numbers of family planning 'acceptors' to be recruited by the programme. Family Planning services were integrated with maternal and child health (MCH) services as part of the Primary Health Care Strategy and services were offered free of cost at government health facilities. MCH service providers at the community level were required to fulfill a specified quota of family planning 'acceptors'. Quotas were accompanied by an elaborate system of financial incentives for acceptors and service providers at all levels, and for institutions delivering family planning services.

It should be pointed out that a dramatic increase in external aid for the transformed programme followed, from USAID and other sources. USAID sent in a ten-man advisory team, provided family planning training in US universities, and gave loans and grants for equipment and supplies.[15]

During 1969-74, family planning was declared a programme of the highest priority and unrealistically high targets were set. There was to be a decline in crude birth rates from 39 to 25 per 1000 over the next ten years. To achieve this, mass sterilization `camps' were set up in make-shift facilities. Medical personnel from referral hospitals contributed their services for a few days at a time, and hundreds of sterilizations per `camp' were carried out each day.

During this period, and particularly after 1975, service providers were threatened with punitive measures for non-fulfillment of targets. Teachers, local leaders and government employees working at the grassroots were all required to recruit women and men for sterilization. Not surprisingly, programme implementation included measures that blatantly violated individual rights and well-being. Not only women, but a large number of men were the victims of compulsory sterilization during the period of political emergency in 1975-77. Little wonder that from only 4.5 per cent of all couples in the reproductive age groups in 1966, contraceptive prevalence rates increased to 17 per cent in 1975 and 24 per cent during 1975-77.[14] The ensuing male protest against coercive mass vasectomies is believed to have brought down the ruling party in the 1977 elections. The programme virtually collapsed in 1977-78, and when it recovered, its focus shifted exclusively to women. Although new targets were set and the programme continued to be well-funded, it became low-key compared to the decade 1966-1976.

Figures on sterilization reflect the rapid change in gender focus. Female sterilisations, which accounted for 46 per cent of all sterilisations in 1975-76, and fell to only 25 per cent in 1976-77, rose to 80 per cent in 1977-78. Throughout the 1980s they accounted for about 85 per cent of all sterilisations, and in 1989-90, 91.8 per cent.

The current renewed emphasis on population control, given part experience, suggests renewed external pressure, and recent happenings confirm this. For instance, despite cuts in most areas of public expenditure, including health, the government's budget for family planning has increased from Rs.3200 crores for the five-year period 1985-1990 to Rs.1000 crores for the one-year period 1992-93 alone.[16]

The UNFPA has increased its assistance from US$52 million for 1985-90 to US$90 million for 1991-95 By1995, the population growth rate is to be reduced from 2.1 percent to 1.76 percent, and the crude birth rate from 30.5 to 26.7 per 1000 population. The use of contraceptives is to be increased from 43.3 percent to 53 percent.[17] USAID has given financial assistance of US$325

million for decreasing the total fertility rate in Uttar Pradesh, the state with largest population and highest fertility and mortality levels, from 5.4 to less than 4, and increasing couple protection rates from about 35 to 50 per cent by the year 2000[18] This is the largest programme of Foreign assistance for reducing population growth rates that the country has ever embarked upon.

The opposing pulls exerted, on the one hand by the massive influx of funds for population reduction, and on the other by economic constraints on women's ability to opt for voluntary fertility control, is likely to set the programme on an aggressive path once again.

Such a trend is already evident. In an attempt to drastically reduce birth rates, new contraceptives such as the contraceptive vaccine developed in India, whose efficacy and safety has not yet been adequately tested, are being considered for introduction into the programme.[19] Others, such as the oral pill Mala, are being freely distributed by community level workers and sold over the counter. The information leaflet with this brand does not mention any contra-indications or possible adverse contra-indications or possible adverse effects; in fact it claims that there are none (Figure 1). Norplant, a subermal implant, is being introduced without adequate training for service provides or improvement of infrastructural facilities to ensure aseptic insertion and removal of the method. The prognosis for women gives cause for grave concern.

Figure 1

INFORMATION FOR MALA USERS

`Mala'

The low dose birth Control pills.

* Children's Welfare is parents' responsibility
* It is very effective to young and healthy women
* Pill use is necessary to have gap between children
* By stopping the use of pill one can have pregnancy.

Instructions for use.

1. Start taking `Mala' from the fifth day of the Menstrual period (Counting 1st day of bleeding as day No.1) Begin with the first pill marked `start'.

2. Continue taking one pill a day along with direction of arrow mark at fixed time. Develop the habit of taking pills at a particular time of the day preferably either after dinner or before going to bed.

   After taking 21 pills one each for 21 days, take one orange pill a day for 7 days.

3. You have regular menstruation while taking the orange pills, Don't discontinue even if you have the period.

4. When the orange pills are exhausted, continue taking pills from a new packet as instructed above. Until you want to have a child/another child, maintain the practice.

`Mala' is most popular, reversible and also simple method of effective contraception. It is used by over 65 million women in the world.

`Mala' is associated with reduced incidence of iron deficiency anaemia due to menstrual blood loss, besides proving effective contraception and regular cycle of menses.

Among other benefits that women obtain from MALA are:

Protection against pelvic inflammation diseases, ectopic pregnancy, endometrial cancer or ovaries and benign breast diseases.

English version of the Mala information leaflet in 15 languages, Eupharma Laboratories, Bombay, for the Ministry of Health & Family Welfare, New Delhi..

Women: access to fertility control measures

What has been the impact of India's population reduction programme on women? Before examining this question, it is appropriate to clarify that fertility decline is definitely in the interest of women's health. Many more Indian women would adopt fertility control measures but for the numerous barriers in their way.

There are wide variations in the impact of the programme in different parts of the country. Contraceptive prevalence rates are highest in Kerala (80 per cent) followed by Tamil Nadu (56 per cent), and lowest in Uttar Pradesh (28 per cent).[20] Overall, contraceptive prevalence among women increased from 23 per cent in 1981 to 43 per cent in 1990.[14,21]

However, the programme has been used mostly by women who do not want any more children, who are at a relatively low risk of pregnancy. This is clear from Table 1.[11,14]

As a result, fertility decline has not been commensurate with the increase in contraceptive prevalence. The total fertility rate was 4.5 in 1981, and 4.1 in 1989.[11] Crude birth rates, targeted to fall to 21 by the year 2000 hovered around 30 per 1000 in 1991.[3]

There is also evidence of considerable unmet need for family planning. A 1988 all-India survey found that 18 per cent of all couples, 24 million, wanted no more children but were not using any contraceptive method.[20] As far as the poor are concerned, little or no increase in contraceptive prevalence may have been achieved, as will be shown below.

There are exceptions to the overall trend. The experience of Tamil Nadu in South India is instructive, as it defies the usual views on the imperatives for demographic transition. Tamil Nadu has had a rapid decline in fertility rates during the 1980s, from 3.8 to 2.4 overall and from 4.1 to 2.6 in rural areas.[11] Couple protection rates have doubled, from 28.2 per cent to 56.2 per cent.[14] Tamil Nadu's infant mortality rate was 84 in 1988, as against only 28 for Kerala, whereas their fertility rates were similar, 2.4 for Tamil Nadu and 2.2 for Kerala. At the same time, perinatal mortality rates and stillbirth rates, indicators of women's health during childbearing years, showed an increasing trend and remained above national averages. These rates are 56.2 per 1000 births and 15.6 per 1000 births in Tamil Nadu, as against 53.8 and 10.4 for India as a whole. Moreover, morbidity rates for women are higher than most other states, and mortality rates have remained stagnant.[11]

Some protagonists of population reduction have hailed this as a major victory for the programme. There is no need to wait for development, they say, to bring about fertility decline. Family Planning can do the job single-handed.

Table I							
Age groups (currently married women)	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Age specific fertility rates per 1000 women (1987)	255.3	319.8	231.9	144.3	85.1	40.0	15.1
Proportion among contraceptive users (1988)	0.8	16.5	36.7	29.3	13.7	-3.0-	

Whatever the reasons for the rapid decline of fertility in Tamil Nadu, it is hardly the success story it is made out to be. Fertility has indeed declined, but there has been a total failure to achieve better health and quality of life for women, men or children. We have yet to learn from the women concerned why they are having fewer children while women from other parts of the country, living under similar economic and social conditions, are unable or unwilling to do so.

Whatever their reasons, the situation in Tamil Nadu demolishes the assumption that the Indian population programme, in its present form, supports development at all. In fact, in its own terms, the programme has failed to achieve its own goals. It has failed to cause a significant decline in fertility in many parts of the country and failed to meet the family planning needs of a sizeable section of the population. This has happened precisely because it treats women as an incidental and manipulable variable among all the factors determining fertility, and high fertility itself as a significant problem only because it leads to a net increase in population.

Imposed from above, under pressure from powerful funding sources to deliver the goods, and operating in sub-standard conditions of service provision, the programme has transformed women into uncooperative `targets'. Coercion and high-handedness are endeminc, from the very top all the way down to the family planning worker, These programme characteristics have seriously helped to compromise women's health and well-being.

The Family Plainng Programme and Women in Rural Poor Communities

The following is an analysis of the limitations of the Indian Family Planning programmes, based mainly on research carried out by me with women from two poor communities, one rural and one

peri-urban, in two villages in Tamil Nadu in 1989-90. In this study, all households with women of reproductive age were surveyed through a questionnaire, followed by in-depth interviews with 64 women. Although the literacy rate among the women, numbers of women working outside the home, and access to a range of health facilities differed substantially between the two communities, they both had the same contraceptive prevalence rate of only 2.27 percent. This was despite their having physical access to health facilities and an expressed desire to limit family size.[22] This study and evidence from other parts of the country show that India's population policy has adversely affected family planning service provision and therefore women.

One serious limitation of the programme is that it has introduced family planning services in a context of high reproductive morbidity, without the back-up of comprehensive reproductive health care. This acts against the programme's interests by discouraging women from seeking contraceptive services. One in three women in the tamil Nadu study had an infection of the genital tract. Similarly Rani Bang et al found in rural Maharashtra that more than 46 per cent of women examined were suffering from an infection of the genital tract.[12] She has seen firsthand that IUD insertions or sterilisation performed without treating these problems aggravates them and causes women further suffering.[23] If,on the other hand, doctors refer women for treatment elsewhere ant ask them to come back afterwards, many are unable to find the opportunity to return, and may find themselves burdened with an unwanted pregnancy.

Post-partum sterilisation of IUD insertion becomes impossible in cases of complications in pregnancy and/or delivery, which was true for 40 per cent of women in the Tamil Nadu study. The consequence may once again be an unwanted pregnancy.

Fear of secondary infertility, which can result from infections of the genital tract in the absence of timely and effective treatment, dissuades women from spacing their births before they have had the desired number of children. High pregnancy loss rates, ten percent of the Tamil Nadu women's most recent pregnancies, reflect their poor health status and have a similar influence on birth spacing.

Even without reproductive health problems, many women are in poor health, with chronic fatigue, backaches, hyperacidity, worm infestation and so on. They hesitate to adopt contraceptive technologies because the health risks are unknown to them. In fact, some of the Tamil Nadu women who had opted for sterilisation had been turned down. They were left to risk a future pregnancy because of their anaemic condition or other chronic health problems such as tuberculosis.

Since 1966, the `integration' of family planning with maternal and child health (MCH) services has diverted scarce resources and personnel away from women's maternal health needs, and has also encouraged the shift of responsibility for family planning

exclusively onto women. Driven by the need to fulfill specific quotas of family planning acceptors and threatened with punitive action for failing to do so, MCH service providers at the community level give top priority to recruiting `cases' for family planning. Antenatal care is reduced to tetanus toxoid immunisation in the best of circumstances, and post-partum care is unheard of.

Further, since family planning services are made available only through MCH services, unmarried adolescents and other single women are denied access to contraceptive services.

Training of service providers is inadequate. Training accounts for less than one per cent of the family welfare budget.[24] The consequences can range from higher than necessary failure rates in the use of women-controlled methods and in provider-controlled procedures such as sterilisation, to an inability to respond to client needs. It has been reported that service providers are often unable to remove the IUD when the thread had retreated or turned inward.[23]

A study of family planning service providers at the community level in Uttar Pradesh showed that they had very limited information about contra-indications and adverse effects of various contraceptive methods. For instance, less that 9 percent named genital tract infections as a possible adverse effect of IUD insertion, and more than 80 percent said that tubal ligation had no adverse effects whatsoever.[25] In rural Tamil Nadu, it was found that service providers knew nothing at all about new technologies such as Norplant and RU-486, which they may soon be expected to provide.[26]

Other aspects of quality of services also leave a lot to be desired. There are no check-ups or counselling before method introduction. This jeopardises the health of women contra-indicated for various methods. For instance, it is not advisable for women with a history of liver diseases to go on the pill. Hepatitis A infection is endemic in various parts of India, yet oral contraceptive pills are freely distributed. No check-ups are done for pregnancy, let alone genital tract infections, before starting a woman on a method such as the IUD.

There is also practically no follow-up after method adoption, even in the case of sterilisation. Very often women have developed fever and puss formation in the wound, but did not know what to do about it. This is mainly because they have been discharged without any intructions regarding possible complications or post-operative hygiene, and because no health personnel have visited them at home to check or dress the wound. One of the most detrimental factors in service provision has been the limited choice of methods available. Women are expected to be mute recipients of whatever the programme makes available to them. What is available is decided on the basis of programme efficacy, not on women's needs or preferences. Those who have no children can have the oral pill, those with one child may have

an IUD inserted, and those who have two or more children are given no choice other than sterilisation. Even the type of pill, IUD or sterilisation is limited, and has more to do with what foreign donors are prepared to fund than other considerations, a limitation that has characterised the programme since its inception.

In effect, the famiIy planning programme has largely been a sterilisation programse, which the incentive system is partly responsible for. Under the incentive system, performance is evaluated according to the number of `sterilisation equivalents' achieved. Sterilisations have the highest weight, IUDs a distant second, and oral pills and condoms the least. Targets can therefore be met and incentives availed of far more easily by concentrating on sterilisations.

This lack of choice was often cited by women in the Tamil Nadu study as a reason for their non-acceptance of Family Planning. Many of them did not want more children, but they were afraid of risking a non-reversible method after only two or three children, because of the high risk of child mortality.

Limiting `choice' to sterilisation also leaves out women for whom time constraints and lack of social support are major problems. Since sterilisation involves hospitalisation, women have to arrange for farm work, childcare and household tasks, including fetching of fuel and water, to be attended to in their absence. There would be no rest on their return, unless there was household help. And a companion is needed to accompany a woman to hospital and attend to her needs there.

Despite the millions of rupees spent on information, education and communication (IEC), detailed information on the different contraceptive methods and their pros and cons is still unavailable to the majority of women. What they get instead is a lot of propaganda on why they should have fewer children. All the women covered by the household survey in Tamil Nadu knew of sterilisation, both male and female. All had heard of mini-laparotomy and laparoscopic sterilisation. However, these were the only methods known to most. Less than 5 per cent knew of the IUD. Of 1307 married women coverd by the survey, only one knew obout the pill. Even regading sterilization, all that most women knew was that it was an operation that stopped them having children. Knowledge of adverse effects was based solely on the experiences of other women, and nothig was known regading contra-indications.

Service providers do not take clients into confidence regarding the contra-indicationt of various contraceptive tecnologies, or possible side effects. They seem to believe that women from poorer communities are incapable of making intelligent and informed decisions if they know the risks involved.

The same attitude governs their apporach to adverse effects reported by women. Women are treated as incapable of assessing

under false pretexts unless they agree to pay as much as five hundred rupees, equivalent to more than a month's wages for many. In contrast, a traditional abortionist charges only ten rupees per month of gestation, and other private practioners charge about three hunderd rupees for services provided far more discreetly.

Taken, together, all of these programme characteristics have made family planning services the least credible and most distrusted of all the health services provided by the government.

There are, in addition, other formidable constraints to fertility control. There is tremendous social pressure against interfering with natural processes before minimum fertility goals have been achieved, which includes at least two sons. Husbands' disapproval of birth control, which is viewed as encouraging promiscuity, was mentioned by many women. Then there is the most difficult barrier of all to overcome, namely women's lack of decision-making power in a male-dominated society.

In conclusion, if the family planning programme is to succeed in reducing fertility, it cannot continue to be imposed from above, as a means of reducing a population growth. It has to accompany the creation of societal conditions conducive to fertility reduction. And women's needs and self-denied interest must dictate programme priorities and strategies, rather than demographic projections and calculations.

An alternative policy framework

An alternative policy framework, that does not conflict with but supports women's interests and successfully deals with the country's economic problems, will treat the population problem as more than a problem of large size and unsustainable growth rates. A redefinition of the population problem, taking into account its many dimensions, is called for.

While population growth is a problem in India, it cannot be pinned down as the only cause of the country's economic problems. No doubt, there are limits to agricultural growth, employment opportunities and exploitation of natural resources. Sustaining a growing population of more than 840 million is a formidable task. However, India's large size and relatively fast population growth are but two of the many dimensions of its 'population problem'.

Another is the mismatch between population and resources. The vast majority of people have little or no land, no access to or control over any productive resources, little education and few skills. A small minority control access to most resources.

Then there is the problem of spatial distribution of population, with urban areas getting increasingly crowded with migrants in search of work. Overcrowding, pollution, and the absence of

their own health problems and tend to be dismissed when they approach service providers with complaints following adoption of a contraceptive method. One interviewee, who wished to have her IUD removed because of exsessive bleeding, was given iron suppliments to compensate for iron loss and sent away. Some of the women fitted with IUDs sufferd very badly from vaginal infections but did not recieve treatment despite approaching the health facility for help.

Sex education also remains neglected. Many of the Tamil Nadu women knew nothing about what makes menstruation happen, and little about conception except that it was related to sexual intercourse - even after they were married and had borne several children. This lack of knowledge can precipitate unfounded fears about contraceptive methods, and unrelated health problems may be associated with them. For example, women feared that the IUD would enter the abdominal cavity and could cause serious health problems.[23] Hyperpciditpy was reported in the Tamil Nadu study as a side effect of sterilisation.[22]

The system of target-setting and incentives has indirectively condoned unethical medical practices. Health facilites are known to have pressured women seeking abortion into accepting sterilisation. IUDs have been inserted and women sterlised after delivery without their knowledge. Information about possible adverse effects and check-ups for these are at times deliberately withheld in order to meets targets.

Two of the women interviewed had been fitted with an IUD without their knowledge, following their first delivery in a referral hospital in Madras. They discovered this only a few months later, upon consulting a gynaecologist for problems with bleeding. Both had their IUDs removed. Today, despite having two and three children respectively, they are nervous about seeking family planning services. Women who do not want to adopt birth control are thus left with little option but to give birth or have an abortion outside a health facility.

Unless women are guaranteed the freedom to refuse, change or stop using contraceptive methods, for their own reasons, they will be strongly discouraged from using them, inspite of perceived benefits.

Thus, a large number of women have an unmet need for family planning. Unwanted pregnancies are a common feature, and abortion the only solution. Abortion is legal and supposedly available free of cost at government health facilities, yet backstreet abortions are preferred and widespread. Why?

There is usually a long waiting period which may extend beyond three months of gestation. Second, it seems to be common practice, although not official policy, that for women with more than two children, health facilities insist on sterilisation as a condition for abortion. Further, in many health facilities, abortion is not free in practice. Women are denied services

basic amenities have led to a deterioration in the quality of urban life for the majority of urban dwellers.

An imbalance exists in the population sex ratio. There are far fewer females than males-929 females per 1000 males - a phenomenon linked to women's low status, especially in the past, and the slow pace of its improvement.

Moreover, health indicators are still among the poorest in the world. Infectious diseases related to enviormental factors, such as malaria, cholera and tuberculosis, are major killers. High fertility features as a serious health problem affecting women.

A policy package that address the "population problem" will therefore include redistribution of land and other means of production, and facilitate access to education and skill development for those who have so far been denied it. Suitable rural development polices that generate adequate employment and other facilities and deter urban migration will be implemented, along with measures to meet at least the minimum necessities of life for urban settlers.

Gender-conscious policy ,measures will be designed to designed to address various facets of women's low status such as low educational and skill levels, excess moratality in infancy and childhood,and poor health. High priorty will be accroded to improving the health of the population, backed by adequate resoures.

Clearly none of these will violate women's interest. On the contrary, they will usher in real developent that ensures the well-being of the population and improves its quality of life. In doing so, they will also create social conditions conducive to fertility reduction.

A component of this policy package will be a family planning progammed designed to meet women's and men's needs. In the presence of suitable conditions, fertility reduction will ensue, and population growth rates will slow down.

The family planning programme will have the following features:

* It will be part of an intergrated progamme of health care for women, provided as now by the public health services, free of cost. Areas such as trained attendance at childbirth and reduction ofmaternal and other reporductive morbidity and mortality willbe accorded top priority.

* Services will not be for married women alone. However, male acceptance offamily planning will be an imprortant area of concerted action. In this regard, the policy of offering family planning services in MCH facilities must be broaden to include sites where men andthose who are not married are also welcome and likely to attend.

* A move will be made away from the programme's current preoccupation with sterilisation. Women will have the choice of a wide range of reversible methods of contraception as well.

* A commitment to improving quality of care will inform and guide all aspects of the programme:

a) Objetive information on contraceptive methods will replace the propoganda of the present programme and will be made accessible to women through innovative dissemination techniques. Instead of `selling' only the benefits of methods, women, will also be told about their limitations and any grey areas, particularly with new methods. Research would attempt to identify the extent of risk for women with high levels of reproductive morbidity, infectious diseases and poor health status. Guide lines for safe provision will reflect this increased awareness.

b) Good quality services, including for abortion, will be avalible on demand. Councelling will be an intergral component of service provision. There will be no coercion whatsoever, implicit or explicit, or restriction of contraceptive method except for valid medical reasons.

c) All necessary medical check-ups will be carried out, without any attempts to cut service costs at the cost of women's health.

d) Follow-up will be an essential and routine part of service provision, without waiting for women to present with complaints. Service providers will make house visits at at regular intervals, if only to assure women that they will be taken care of.

e) Women approaching service providers with method-related and other complaints will be taken seriously and given promt and adequate medical attention. Should they wish to stop using a method or change to another, their wishes will be compiled with, due respect for their ability to decide what they can and cannot cope with.

Most of these proposals will not require a huge additional budget, because the current budget is already huge. They will require a basic change in attitudes, in how expenditure is allocated and in implementation strategies. For example, incentive payments for `acceptors' and `motivators' alone consumed about 12 per cent of the 1989-90 family welfare budget, and that does not include incentives paid to the service providers.[27] The elimination of these payments would free up a large part of the budget.

It will also take concerted efforts and political will to change the negative image of the progamme and earn people's trust. Retraining and reorientation of service providers away from the target approach, rewarding sensitivity to people's need instead, would be a good starting point.

Further, the additional investments now being made as, well as money currently mis-spent on incentives and propoganda, can be

effectively channelled towards improving the quality of information and care.[27]

It needs to be re-emphasised that these changes in the family planning programme must be made in the context of a larger policy package that deals with all dimensions of the population problem. Few other options are open if the aim is to support women's well-being and tackle population problems at the same time.

Conclusion

It will be argued that India cannot afford such far-reaching and long-term interventions, considering its current situation. But all the evidence since 1966 refutes such assertions. Reducing population growth in itself has not solved any other existing problems, and has probably even accentuated some of them, including in Tamil Nadu, where rapid fertility decline has occured. What India cannot afford is an ideological stance that promotes exclusive faith in birth rates decline as intrinsically good, a goal to be pursued for its own sake, no matter what the cost to women.

References and notes:

1. Salsena, Rashmi, 1991 Birth pangs,
The Week, 22 Mar:28. Cover Story.

2. GNP grew at 4 per cent during 1950/51-1963/64 and 3.4 per cent between 1967/68 and 1979/80. Indicators of food production are as follows:

Period	Average annual growth rates for		
	Area under cultivation	Yield	Production
1951-52 to 1969-70	1.2%	1.4%	2.7%
1969-70 to 1980-81	0.4%	1.4%	2.2%
1980-81 to 1990-91	0	3.2%	3.4%

The consumer price index for agricultural workers (1960-61=100) grew for food item from 359 in 1980 to 702 in 1989; the corresponding figure for industrial workers are 362 and 807. The rise in general rice index is even higher. 333 in 1980 to 690 in 1989 for aricultural workers, and 350 to 775 for industrial workers. Source: Centre for Monitoring Indian Economy, 1990. Basicstatistics relating to the Indian economy. 1: All India, August 1989. New Delhi.

3. Work participation rates grew very marginally between 1981 and 1991, from 36.7 to 71.68. Source:Government of India, 1991. Census of India, 1991 provisional population tables. New Delhi.

4. Suryanarayana M H,1986. The problem of distribution in Indian development: an empirical analysis.Ph.D. dissertation submitted to Calcutta University, India.

5. Population growth rates for India as compared to other developing countries during the period 1951-81 are as follows:

Population growth	1951-61	1961-71	1971-81
India (census figures)	1.98	2.24	2.26
Africa	2.27	2.56	2.82
Latin America	2.75	2.70	2.38
W.Asia	2.75	2.75	2.88
S.E.Asia	2.10	2.45	2.28
E.Asia	1.64	2.20	1.76

Source: United Nations, 1989. World population trends and prospects 1988. Population Studies No.106, Department of International Economic and Social Affairs, New York.

6. For instance, according to the economic surveys published annually by the Government, production of cars and jeeps increased from only 47,000 in 1970-71 to 172,000 in 1987-88; of two wheelers from 97,000 to 1,541,000 and refrigerators from 67,000 to 680,000 during the same period.

7. The share of consumer goods in the value of imports increased from 2 per cent in 1980 to 14 per cent in 1990, and of intermediate goods used in production from 33 per cent to 44 per cent during the same period. Source: World Bank, 1991. India, Trends in developing economics 1991. Washington DC.

8. This is already happening. IMF borrowing led to abiding by the conditionalities that go with the package. This included a drastic devaluation in 1991 which led to increased costs of imports, causing a further escalation of price levels. High inflation was threatening to negate the anticipated export promoting effects of devaluation, and to keep exports competitive the country was already being forced to consider further devaluation by the end of 1992. There have been cuts in Government subsidies on fertiliser and food prices, making food prices rise even further. Expenditure on social services, including health and education, have been cut. There has been little capital investment by the government, which will seriously hit infrastructural development in the coming years, and in turn, employment. Public sector enterprises that are not viable are to be closed down, further aggravating the unemployment situation.

9. Government of India, Planning Commission, 1989. Indian planning experience: a statistical profile. New Delhi.

10. National sample Survey Organisation, 1987. Report on the quinquennial survey on employment and unemployment, survey result: all-India. Thirty Eight Round, No.341. Dept. of Statistics, Ministry of Home Affairs, Government of India, New Delhi 337-338.

11. Registrar General of India, (various years). Sample registration system. Ministry of Home Affairs, Government of India, New Delhi.

12. Bang, R A et.al, 1989. High prevalence of gynaecological diseases in rural Indian women. Lancet.337 (14 Jan): 85-88.

13. Denoon, David B H, 1986. India: expectations shattered Appendix 2 C: The Woods-Mehta Agreement. Devaluation under pressure: India, Indonesia and Ghana. MIT Press, Cambridge USA, 78.

14. Although India had a family Planning progamme since 1951, more than fifften years after the programme was initiated, in 1966, the percentage of couples effectively using contraception was only 4.5 per cent. Source: Department of Family Welfare, 1991. Family Welfare programme in India Year Book 1989-90, Goverment of India, Ministry of Health and Family Welfare, New Delhi.

15. Assistance in 1967 was US$ 127,000; 1968, US$ 7,721,000. This included a US$ 350,000 assistance to the pathfinder fund to aid NGOS, and US$ 100,000 to the population council to initiate a postpartum program of sterilisation in 150 hospitals in India. In addition PL 480 agreement for food aid in 1968 allocated about US$ 4,000,000 in local currency for use in Family Planning programmes. Source: Reimart T. Ravenholt, 1969. The A.I.D. Population and Family Planning Programe: goals, scope and progress, in: Population: international asstiance and research. Proceedings of the first Population Conference of the Devlopment Centre of OECD, 3-5 December 1968, Paris, 78

16. Figures from 1992-93 budget and source in reference(9).

17. United Nations Fund for Population Activities, 1992 India's population programme: the prime concern of UNFPA, New Delhi. (promotional pamphlet)

18. Times of India, 15 Feb 1992.

19. Planned Parenthood Bulletin, Family Planning Association of India. 1991; 39 (Nov).

20. Operation Research Group, 1991. Family Planning practices in India, third all-India survey. New Delhi, 85.

21. According to leading Demographer Mari Bhat, these are overestimates. His revised estimate of CPR in India in 1988-89 is about 30 per cent. Source: Mari Bhat, PN et al, 1990. Fertility and Family Planning in pre and post-emergency India: Towards a reconsideration of diverging trends. Unpublished research report.

22. Sundari Ravindran, T K, 1992 USERS' Perspective on the appropriateness of particular methods of Fertility regulation for particular settings in Asia. Prestented at Women's Prespectives on the Introduction of Fertility regulation techniques, 5-9 Oct, World Health Organistion Asian regional Meeting, WPRO, Manila. (mimeo)

23. Bang, Rani and Bang, Abhay, 1991. Contraceptive technologies and rural Indian women. Prestented at the MacArthur Foundation meeting of women's health grantees, 1-3 July, Teresopolis (mimoe)

24. The amount spent on training as a proportion of the total budget for family welfare was 0.5 per cent for 1985-86 and 1986-87, and rose to 1.2 per cent in 1989-90. Source:reference [14].

25. Alok, S K, 1990. Status of Family Planning and MCH services by village level functionaries in Western UP. Ministry of Health and Family Welfare, Government of India, New Delhi.

26. Anecdotal evidence.

27. The incentive payment to `acceptors' and `motivators'. (together) is Rs.210 for female sterilisation, Rs.180 for a vasectomy, and Rs.11.25 for an IUD. A rough calculation based on the number of `acceptors' reported officially for the year 1989-90 that the amount spent on incentives to acceptors and motivators alone is about Rs.923 million. Calculated from figures reference [14].

Courtesy: Reproductive Health Matters, London, No 1.MAY 1993.

SOME BASIC ELEMENTS OF REPRODUCTIVE RIGHTS

1. Women's right to regulate their own fertility safely and effectively by conceiving when desired, by terminating unwanted pregancies, and by carrying wanted pregnancies to term.

2. Right to remain free of disease, disability, or danger of death due to reproduction and sexuality. For example, sexual abuse domestic violence, sexually transmitted diseases and HIV/AIDS.

3. Right to protection of maternal health and prevention of maternal mortality.

4. Right to safe and legal abortion.

5. Right to full and accurate information on the benefits and risks involved in use of drugs, devices and technologies for regulation and control of fertility.

6. Right to receive and disseminate information on sexuality and reproduction.

7. Prohibition of discriminatory laws and practices that seek to control sexuality and sexual preferences.

8. Right to individual women to make a choice of contraceptive methods/tecnologies.

9. Right to quality health services with special emphasis to meeting the reproductive health needs of women.

10. Prohibition against restricting the civil and political rights of citizens for the purpose of implementing population regulation policies and programmes.

POLITICS OF POPULATION AND DEVELOPMENT

The Draft National Population Policy, while it continuously refers to the empowerment of women, is virtually silent on the growing feminisation of poverty in India, on the problems of women's status within the family, the domination and violence which characterise the working of the family and women's lack of access to independent incomes. Its reference to gender equity and to free and informed choice for women merely reflect its uncritical and deliberate assimilation of the vocabulary of women's groups.

The debate on what has come to be characterised (unfortunately) as the `population problem'in this country has now taken two distinct lines depending on the ideological proclivities of the debators. The Draft National Population Policy and its supporters have posed the problem of an unimpeded population growth in terms of its implications for growth is the chief obstacle to development and that it comes in the way of ensuring a better standard of living and better health care for the people of this country. It assumes that the land-people ratio and the optimum carrying capacity of our planet ought to be discussed in the context of ever growing numbers of the poor.

The critics of the Draft National Population Policy, particularly most of the women's groups, reject the above understanding of our current situation. It seems to us that the attention given to population growth as a major cause of India's economic problem has ignored the extent to which India's development model adopted since independence is responsible for its severe economic crisis. This model can be characterised as growth with inequality. While the report lays great stress on north-south inequality, it is reluctant to address the problem of growing economic disparity within the country and the long term ill effects of the new and evolving economic policy which is certainly not pro-poor, pro-environment or pro-women. It is also important to recognise that the "ever teeming millions" pose a problem not in terms of their numbers but because they constitute an expanding consitutency of the poor, the malnourished, the diseased and the deprived. Unless the deprivations of these evergrowing millions are addressed in terms of a better quality of life for them, concerns about population growth will remain a malthusian horror. In this context it is worth reproducing the statement made by groups around the world at the PrepCom II *(reproduced in Legal Perspectives, Document File No.31, Chengalpattu)*:

The population issue cannot be considered in isolation, but should be related to the issue of resource use and wastage as a whole. The north, with 20 per cent of the world's population, uses up to 80 per cent of global resources and is responsible for 80 per cent of pollution that causes the Greenhouse Effect, ozone loss etc. The north with one billion people consumes 16 units of

global resources (since northern per capita GNP is 16 times more than the south's). The south with 4 billion people consume only 4 units of global resources. Thus, the important equation is not so much that "4 out of every 5 people live in the South" but that "4 out of every 5 units of resources consumed are consumed in the north". Even if population growth went to zero in the south, only 20 per cent of the environment problem would be solved because the north (and the southern elite) would still be using up 80 per cent of the global resources.

India's development model has failed to create social and economic conditions that favour fertility decline. Skewed and unequal land distribution patterns uneven industrial growth, growing unemployment and under employment, in short the structural inequality that underpins our economic system and the social inequality that marks our society are factors that have made for a high fertility rate. The report does not take cognisance of these factors and does not seem to think they are important in evolving holistic solutions to development and fertility control. It is tragic that the authors of the Draft National Policy should fail to explicitly integrate population into economic and development strategies; it is worse when they ridicule those calling for such integration by passing remarks such as the following: "There is often a widespread urge to "integrate" population policies with development policies, often with an implied presumption that the success of the former is inextricably linked with the success of the latter. In recent years the concept of integration has acquired a certain amount of halo or sanctity, similar to motherhood" (Pravin Visaris, `Population Policy for India 1990s and Beyond', 7th KS Sanjivi Endowment Lecture, August 15, 1994).

While the report refers continually to a holistic and `comprehensive' approach to health, this approach does not go beyond conventional maternal and child health care. While it adds to the list of health services for women it is nearly silent on the evolution of a total health programme. The report's integrated approach is manifest only at the level of bureaucratic reconstitution and scant attention is given to expanding primary health care and to training a more professional, sensitive and accountable health work force. Further the current renewed emphasis on population control, given past experiences, suggests renewed external pressure, and recent happenings confirm this. "For instance, despite cuts in most areas of public expenditure, including health, the government's budget for family planning has increased from Rs.3,200 crore for the five-year period 1985-1990 to Rs. 1,000 crore for the one-year period 1992-1993. The UNFPA has increased its assistance from US $ 52 million for 1985-90 to US $ 90 million for 1991-95. By 1995, the population growth rate is to be reduced from 2.1 per cent to 1.76 per cent, and the crude birth rates from 30.5 to 26.7 per 1,000 population. The use of contraceptives is to be increased from 43.3 per cent to 53 per cent. US AID has given financial assistance of US $325 million for decreasing the total fertility rate in Uttar Pradesh, the state with the largest population and highest fertility and

mortality levels from 5.4 to less than 4, and increasing couple protection rates from about 35 per cent to 50 per cent by the year 2000. This is the largest programme of foreign assistance for reducing population growth rates that the country has ever embarked upon" (T.K. Sundari, `Women and the Politics of Population and Development in India', *Legal Perspectives*, Document File No.36, 1994).

The report refers continuously to the empowerment of women. How is this empowerment to be brought about? Much noise has been made about the doing away with targets. While the abominable practice of setting targets for the administration of particular fertility control measures certainly needs to be done away with, there is need to lay down quantitative goals particularly in three areas that are mutually supporting and of critical importance to the achievement of other important population and development objectives. These areas are: education, especially for girls; infant, child and maternal mortality reduction; and the provision of universal access to family planning and reproductive health services. The authors of the Draft could have displayed their political commitment to the empowerment of women by, for example, accepting the goals set by the World Summit for children, held in 1990, namely, a reduction in infant and under-5 child mortality rates by one-third, or to 50 and 70 per 1,000 live births, respectively, whichever is less. We do not need to labour the point that "child survival is closely linked to the timing, spacing and number of births and the reproductive health of mothers. Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality remains high, couples often have more children than they otherwise would to ensure that a desired number survive." (1)

The report is virtually silent on the growing feminisation of poverty in India. Its reference to gender equity and to free and informed choice for women merely reflect the report's uncritical an deliberate assimilation of the vocabulary of women's groups and women activists. Apart from stating that the new policy will work to check the shifting of the burden of family planning onto women and aim to foster a "culture of joint responsibility of the couple", the report no where alludes to the problem of women's status as such in the family, the dynamics of control, domination and violence against women which characterise the working of the family and the lack of access to an independent income, that most women suffer. The report is also silent on the use of coercion and consent, of economic power, and cultural authority within the family to secure and perpetuate the subordination of women. It is clear that unless a working model of the various types of families and their dynamics is posited, notions of `joint responsibility' cannot simply be realised in practice, nor can policies and programmes be sufficiently sensitive to the needs and rights of women and children.

The report envisages a major role for panchayat raj institutions in the implementation of the proposed population control programme but its conception of these institutions and their viability is severely limited. Panchayati Acts, as amended in the various states, have been examined, analysed and criticised by political observers, scientists and other concerned citizens. Questions have been raised about the financial viability and the administrative and political powers of even amended panchayats, and, studies have been carried out on existing panchayati raj institutions in particular states. But the report has not taken into account these debates and seems to be unduly euphoric about the possibilities of panchayati raj institutions. Neither has the report taken into consideration factors such as caste and economic status that are bound to influence the composition of panchayats. The report is also not clear as to the exact linkages that ought to obtain between panchayati and nagarpalika institutions, state governments and the proposed new commission.

The report is equally silent on the impact of the new economic policy-with its centralising tendencies, particularly in terms of transfer of resources to the states-on the proposed process of decentralisation. It is clear that unless the possibilities of a decentralised mode of working are considered in the context of the changes wrought by the new economic policy, decentralisation will remain merely a formal (and fashionable) proposition than a substantive one. The report contradicts its own attempts to privilege panchayati raj by announcing that ultimate responsibility for implementing policy and making decisions will rest with a centrally constituted committee, namely, the Population and Social Development Committee (PSDC). Not only has the report not drawn out any broad, concrete guidelines as to the functioning of the PSDC with respect to the various decentralised levels of the policy but it has also not recommended any means/methods through which the PSDC may realistically assess local needs and resources. Neither has the report specified as to how panchayat level representatives will be heard, heeded and made part of the decision-making team at different levels of government.

Certain details contained in the report are truly shocking: (a) The report envisages measures such as consideration of age of marriage, adoption of small family norm, to be enforced in matters of recruitment to and promotion in government jobs. Besides, following the example of panchayat acts as amended in Haryana and Rajasthan it proposes to debar persons with more than two children from contesting elections to panchayats. There seem to be punitive measures that no democratic-minded person can approve of. Besides, the example of these two states is unfortunate since lowered fertility rates there co-exist with adverse sex-ratio. It is also extremely unfortunate that, its democratic intentions notwithstanding, the report should imply that women of child-bearing age -- often the younger and more eloquent and politically alert of the village female population -- should be disallowed from contesting elections. This not only discriminates against women but more realistically will put

younger women in a double blind: if they have mothered only daughters, the family pressure to produce a son will work on them; at the same time the proposed disincentive through debarment will exert its own pressure. In such a context they may not be in a position to make use of the 30 per cent reservation allowed under the new panchayat dispensation.

It is difficult to understand how the report with its ostensibly pro-people image could endorse the freezing of the number of seats in the parliament and legislatures. Not only is this patently undemocratic but it grants a lie to the report's insistence on `participatory' politics. The use of the term `political commitment' to describe the motivating factor behind the apparent success of the above mentioned and clearly primitive measures in Haryana and Rajasthan is ironic. The representatives of the Indian state need no special commitment to discipline and punish since these constitute tacit but unacknowledged premises of their working ethos. If the authors of the report had stressed on the importance of displaying political (and not merely administrative) will in matters such as ensuring that every child goes to school, that no child or adult labours in inhuman conditions, that women are not unfairly and routinely discriminated against, their intentions would have been laudable.

(b) The suggestion that military and paramilitary forces be used in promoting population control options is truly deplorable. In another context, Ashish Bose (a member of the present drafting committee) while lauding Tamil Nadu's `successful' demographic transition, referred incidentally to the Indonesian experience and concluded thus: "Thus main reason for the success of Indonesia model is the excellent military-style logistics in running the programme. In India we have an overdose of democracy". (`TN's Successful Demographic Transition', *Financial Express*, January 4, 1994). What Bose did not reveal was how the military abused human rights in implementing family planning programmes in Indonesia. To quote Zeidenstein, who headed the Population Council for a number of years and who in an essay describes the Indonesian family planning programme thus: "Norplant has been administered in part by means of `safaris' — operations in which family planning personnel, accompanied by soldiers, enter a village, gather the populace together, and expound upon the advantages of family planning often with an implied threat that the village will be punished if family planning methods are not adopted. These safaris have historically played an important part in Indonesia's family planning programme, typically resulting in village women's mass acceptance of contraception — often of the one method being promoted at that particular moment by the government" (quoted by T.N.Krishnan, `Population policies: Some Issues', book review in *Economic and Political Weekly*, August 6, 1994, p 2076). While we are all for efficient and accountable procedures, being evolved and implemented, we urge Ashish Bose and Co., to concretely explicate how abuse of human rights such as the above will be dealt with and prevented in India.

(C) We are pained at the utter insensitivity with regard to women's health as evident in the report's comment on contraceptive use. Given the adverse side-effect and long-term effects on a woman's body of existing contraceptives of the scientific community, it is shocking the report should casually comment that no contraceptive is without risk. Even a quick documentation of the existing material on the functioning of institutes such as the Indian Council of Medical Research and the family planning association of India will bring out the callous and contemptuous manner in which these bodies deal with humans, particularly, women. For eg., "although an Indian vaccine, developed by G.P. Talwar with support from the population council, the Canadian IDRC and the Indian government, has been tested on only 180 women, it is being billed by the family planning association of India as "safe, devoid of any side-effects and completely reversible". Even the scientific community knows that such assertions are patently false — for instance, many questions still remain about the vaccine's long-term impact on the immune system and menstrual cycle. There is also documentary footage of women being denied information about the vaccine in clinical trials. Nevertheless, the Indian vaccine is being prepared for large-scale use" (quoted in *Medico Friend Circle Bulletin*, May-October, 1993, p 10).

The problem instead is being posed as one of informed choice. However such a choice ought to be made in a context where mechanisms exist to ensure that women (and men) in search of contraceptives do not end up choosing drugs and implants that are positively harmful. Given the fact that women's groups have considerably campaigned against the use of injectable contraceptives that are likely to cause unknown immunological disorders, surely the report should have recommended that the state take a clear stand on banning the production and marketing of these contraceptives? A policy that attempts to give individuals the right to choose contraceptives and plan their family without providing an enabling environment that would render the choice to be automatically `safe' and `risk-free' cannot, for obvious reasons, go very far.

In the face-to-face discussion that representatives of women's groups had with M.S. Swaminathan and T.V.Anthony (the latter is also the former chief secretary to the government of Tamil Nadu), it became clear that such criticisms and misgivings as those listed above would not be heard at length. Swaminathan, for instance, in his response to these, skirted the issues and insisted on referring to the draft policy report to clarify matters. He refused to grant that the report had not sought to consider population policy in the context of our extant model of development. Arguing that the report could not be expected to furnish an economic essay on development he rejected the criticism that it lacked a cogent perspective on the economy, on questions of land and labour. Likewise,, he refused to accept the fact that the report had avoided talking about the new economic policy and its impact on population problems. He was merely content to reaffirm the faded rhetoric as regards the

logic of north-south economic relationship that already exists in the report. Arguing that one has to take the Prime Minister's word in good faith (sic) when in his independence day speech the Prime Minister explained his decision to disinvest in profit-making public sector enterprises to enable a passage of funds gained from cuts in subsidy into social welfare activities, Swaminathan dismissed the criticism as to the lowering the state spending on social issues, lightly.

His responses on other points of criticism were, to say the least, routine and displayed an unwillingness to accept seriously differing and alternate points of view. At one point, though, he was forced to admit that there could be different points of view and he referred to (mysterious) internal discussion papers that recorded the commission's debates. However, one is forced to doubt the existence of these papers, since this was the first time they had been referred to by the authors of the draft; besides, precious little evidence of that ostensibly nu nuanced inner debate was reflected in the policy statement itself.

This brings us to the entirely different problem of the way such commissions function. It seems unfair to release the policy for discussion and then when criticisms are made, revert to unspecified arguments that are recorded in reports one is yet to see. Also to maintain as Swaminathan and Anthony did, that criticisms have to be forwarded to the health ministry since the commission is officially disbanded, not only betrays a poor sense of responsibility and accountability but also a certain unmistakable arrogance and disrespect for criticism and debate. It would be pertinent to record in this context the different strategies adopted by such commissions to confuse and confound various sections of the population. One strategy consists in involving affected groups at various levels ostensibly to open up a dialogue. However, as women's groups particularly have realised, the main purpose of such dialogue sessions is basically to "divine (women's) arguments, appropriate their language and finally exhaust them". Another strategy is to challenge, in this case the women's groups, to produce an alternative document. Our poser to this criticism (the latter) is very simple: without a similar mandate, without similar facilities enjoyed by the Swaminathan committee by virtue of this official mandate, the women's groups are not prepared to fall into this neatly laid out trap in the form of a counter criticism. Further and more important it is not as though alternative proposals do not exists. If only the commission had looked around it would have spotted any number of well-argued out,informed documents both national and international, which have discussed the issue of population in a holistic, more humane framework.

Lastly it has become habitual for commissions to claim that they are concerned above all with policy and operationalisation is not one of their concerns. The question that needs to be raised here is this: of what use is a policy document whose operational

principles are not inherent to its arguments? Especially since policies such as this concern people's (particularly women's) lives, bodies and their very right to life.

Note

[A substantive part of this not by V.Geeta and Padmini Swaminathan is based on presentations made at two meetings (August 6, 1994 and August 29, 1994) held at Madras to discuss the Draft National Population Policy. While acknowledging in particular the contributions made by the principal discussants, namely, K. Nagaraj, Manabi Majumdar, V.R. Muraleedharan and Mythili Sivaraman, the authors would like to thank all the participants at both the meetings. Responsibility for the above interpretation of the discussions however rests solely with the authors.]

(1) For comprehensive details see the *Draft Programme of Action of the International Conference on Population and Development*, Note approved by the Preparatory Committee for the International Conference on Population and Development, 13th May 1994 (mimeo).

SECTION III

EXPERT GROUP ON POPULATION POLICY
GOVERNMENT OF INDIA
Draft of Section 9 from Chapter 2

New directions contribution by Devaki Jain

ISST 19.2.1994

a) Development ethos and directions

b) quality and pattern of economic growth

c) focus on the girl child and women's perspective

d) goal and mission statement

a) Development Ethos

Mahatma Gandhi's barometer of measure for testing the justice, the validity, the relevance, the effectiveness and value of any programme, was to see, assess it affect Daridranayarayan - (Poor man seen as god). Amongst poor people, women tend to be at the bottom of the pile - so I have renamed it Daridranarayani (female suffix). His argument was that if a programme, or policy or act can in some measure reduce the pressure on the last `woman', namely the poorest person, it would automatically affect positively all those above this last `woman'. In other words, it was a belief in what could be called the "bubbling up theory" of growth as different form a "trickle down theory". By attacking the poverty of the last `woman', we would be attacking the very basis of all the evils. By providing relief to this person; we would be illuminating our paths in the right direction.

Population policy has to stake a claim for investment in social and economic security services for poor people as the key to reach the goal of peoples' well being, balancing people with resources.

In order to mutually re-inforce the provision of a basic needs flow, the macro economic policy would need to also focus on stimulating paths of growth in Agriculture and Industry which are sensitive to land, water and power use.

b) Quality and Pattern of Economic Growth

It is increasingly being recognized that the growth of domestic out put, and the increase in the earnings of foreign exchange by themselves do not usher in the element of sustainability,' - either of the resources of the planet earth, or of the social and economic stability of the nation. Very often growth paths of a certain kind not only usher in environmental devastation either through over use of a resource or through the generation of pollution, but also usher in civic breakdown, social conflict, internal instability, due to the imbalance they

may generate in opportunity. Further they are often not able to sustain themselves as their foundations are too fragile and dependent on markets outside our control.

Hence it is suggested here that the growth path and export earnings path have to be derived out of a basic political premise namely that the first task of the nation is to remove people from poverty and deprivation. Provision of an process of constructing a just and capable society. The constraints of making such a floor mobilization of peoples' interest. There are endless examples in India of local initiative including financial contribution.

Decentralization, the PRIs may provide the instrumentality to achieve this goal. However, it will materialize only if the spirit of the 73 amendment is maintained - which means more money and powers to be elected representatives especially women to design and decide the ground level projects and schemes. This is not happening in most states. In most states the chief executives and planners at the district levels are still the civil servants - the funds are still the old schemes. The representative bodies are merely one more non official outpost for the govt. This must be stopped.

Population policy statement must insist that for the country to have a sustainable stabilization of the pop growth rate it must take serious note of and interest in the detail of the PRI system.

It is not development, nor growth by itself, but it is the content and the method - also content in the sense of investment in basic social amentities, institutions which means both the organization and the political culture which gives access to these facilities - DJ Kerala from Jap Paper Thus it is the content and method of development, the focus and sensitivity that needs highlighted.

Today in the population debate when political will is postulated as a necessary condition, it is translated to mean either that politicians should also harangue people to limit their families, or that membership to legislative councils should be given as a reward to those politicians who have few or no children and so on, or that reward and punishment to local elected bodies should be linked to achievement of targets in family planning.

Political will or attention to population should be translated as a will to <u>redress</u> the deprivation of the poor, to provide them with social and economic security as basic services, and then build their capability to avail of these entitlements.

It can then be suggested that for the poor to fulfill their own desire to achieve a sense of well being, in which for women few child births is a strong desire, there has to be a situation where they are offered social entitlements to basic health

services, which of course includes food, may be even livelihood, and then their capacity built to avail of these entitlements, namely through education, information - but not only that but through providing the institutional mechanism that share power, which offer space for groups like women to participate in decision making, and thus to exercise power.

Thus a base for a population policy has to be the provision of a floor - which gives access to income, - it could be a form of employment guarantee, it could be a strengthening of existing labour use pockets but with the exploitation removed (SEWA) - through innovative self help organization. This floor is not to be limited to the economic zone alone, but must include health and education, translated to universal primary education, and universal primary health care. It should also include basic civic amenities like water, energy, sanitation - a blend of economic and social services.

However, the management of the provision of this floor has to be through local self government - as then both the diversity of India, the participation of local communities, especially the voices of the unheard in decision making, the accountability required for monitoring and redressal is assured.

The State should provide the services of economic and social security to the poor but for it to reach the poor this service has to be accompanied by social dynamism - namely the commitment and participation of civic society:- namely political parties, voluntary organizations, the elected bodies and professional institutions. Because to provide a service to the poor is one thing, but for it to reach them is quite another.

The usual question that will emerge when such a big commitment is put on the national exchequer is lack of resources. In fact the Expert Group, should know that in the ICPD (Cairo, UNFPA) document, the G-7 countries have objected to the use of the term "poverty eradication" (they prefer "poverty alleviation") because they say "eradication" is too costly. Remove the poor by population control - we have no money to remove poverty, - is the message from the North, as Malthus stalks the chapters and the propaganda. This political position has been translated to the media with such force that even we in the South have swallowed it.

But is this the case? Can India not afford such a policy? Basically Political will to us mean political choices - and the question is not one of raising resources, but of allocation of resources and also of methods through which the resources can be used.

c) Women's Perspective

Women would say, people, the quality of their life, has to be the central concern of a population policy.

In the context for example of India, they would say - an effective and sustainable population policy has to rest on an understanding of poverty and within it poor women, the characteristics of their life situation, their deprivations and capabilities.

The policy also has to shed many myths and prejudices such as that ignorance and superstition are responsible for large families, that therefore the poor especially women have to be "motivated" through reward and punishment, and scares like the Malthusian argument or the population bomb; or its reverse - that a small family is a happy family and that money can buy or more aptly dry reproductive capacity.

They would say then that political will or attention to population then should be translated as a will to redress the deprivation of the poor, to provide them with social and economic security as basic services, and then build their capability to avail of these entitlements.

It can then be suggested that for the poor to fulfill their own desire to achieve a sense of well being, in which for women few child births is a strong desire, there has to be a situation where they are offered social entitlements to basic health services, which of course includes food, may be even livelihood, and then their capacity built to avail of these entitlements, namely through education, information - but not only that but through providing the institutional mechanisms that share power, which offer space for groups like women to participate in decision making, and thus to exercise power.

Women are interested in the detail. If nutrition is required as a basic pre-condition of health, then they have advice on land use; they draw attention to the role of commodity prices and international trade agreement elements which may shift this use to less food oriented uses or raise costs. They have similar interest in water use - which in turn leads to views on production technologies, on power generating technologies, irrigation systems and so on.

When women recommend education for girls, they recommend piped water and gas to be introduced in every home - as they know that as long as water has to be fetched from ponds and rivers and wells even far away queue lined taps, as long as fuel has to be brought from far away woods or collected from the bush, girls cannot go to school - and now with the break down of self control in most societies every where there is the threat of rape, violence against even little girls as they walk to school across fields. So to reach low fertility rates they start with security from violence, investment in social infrastructure go on to piped water and gas to be available like black boards and teachers; and then on to school hours to suit climatic and occupational needs of poor working families, then on the ensuring that village teachers teach and village nurses, nurse by wanting local accountability for the grass root functionaries.

When it comes to health they see health especially reproductive health as something that has to start being attended to from the earliest age of people and of both sexes, to level up their knowledge and responsibility. They recommend that the department at approach to social inputs be changed to a one line, one window and multiple services across age and gender.

Women all over the world are emphasizing participation in decision making and leadership. Poor rural women identify capability to make decisions as key to their advancement, and of course key to making informed reproductive choice.

But decision making to them does not emerge from literacy or income, but from a sense of balance in power or what can be called equality between themselves and their men. Taking us back to the old concept of equality between men and women not at the macro statistical level but at the household and community level - a very different kettle of fis.

Women's groups construct a whole national policy on population and strategies thereof from the seed or root of decision making, which is now possible in India due to the 73rd Amendment to our constitution which reserves 33-1/2% seats for women in Local Self Government. (See note).

When there is a plea of "no funds"/resource crunch, they recommend choice between groups in education, e.g., universal elementary education before higher education. They say teach us about our bodies and give us information, we will choose the contraceptive.

Literature is full of case studies of women's capabilities in innovative institutional endeavors and also in resistance to threats to life and livelihood. Most of these endeavors indicate choice of issue and method of leadership, challenge the theories of economic growth and social change.

The choice is usually supportive of conversation - whether of natural resources or other forms of resource.

The method is usually one of collective action and consultative process.

d) Goal and Mission Statement

The population policy has to shed many myths and prejudices such as that ignorance and superstition are responsible for large families, that therefore the poor especially women have to be "motivated" through regard and punishment, and scares like the Malthusian argument or the population bomb; or its reverse - that a small family is a happy family and that money can buy or more aptly dry reproductive capacity.

The policy has to acknowledge and believe that the poor and within them women want to have the power to determine the number of children they have. They are no more seeped in ignorance. They are aware of the fact that there are methods by which conception can be avoided - and even more aware of the fact that foetuses can be killed or removed through abortion of many kinds. Most govt. documents mention the cruel phenomena of ill - serviced abortions (by quacks, unsanitary methods etc. that cause deaths among women).

There is also enough survey research to show that even in the most remote areas of India and even amongst the most hidden populations, such as the tribal people living in forests the consciousness of modern methods is there, however hated, disdained or feared. In fact the electoral results after 1975 show that it was in the backward, so called ignorant areas, that this message caused political rejection - not as we would like to believe because the poor were ignorant of the knife and its value, not because of superstition that loss of fertility is loss of life, but because in fact operations turned out to be killers and also because there was enforcement associated with loss of ones rights, or put the other way, with terror.

Further, social research is revealing a less comfortable but similar evidence/results, namely, that these "less visible, less exposed people" are losing their own traditional as methods of restraining the size of their families: traditional forms of birth control especially spacing not only herbal medicine but associated with custom and ritual, and most of of all equality in decision making power between men and women which is the hallmark of tribal and other small communities in India.

Once this postulate is change - namely the analysis move from one of dealing with "ignorant, backward superstitious" people to one of dealing with people who are dealing with their life situation as rationally as they can in their circumstances, the approach would change.

<u>And this has to be the first demystification of population policy</u>

<u>The second</u> is that single prong interventions can transform fertility patterns - namely moving statistical analysis into homs, (or what can be called family decision or couple decisions).

For example: (1) there is the strong premise to all policy documents that literacy inputs into women will bring lower fertility outputs - because we find that in statistical analysis, high rates of female literacy are associated with low fertility. However, it is also know that <u>male</u> literacy not only influences fertility, but the significance is even greater. And then of course we have statistical analysis which shows that male and female are very closely and positively associated, i.e. where male is high and moving up so does female and the reverse. What we are emphasizing here, by this presentation of

literacy/fertility data is NOT that education, literacy do not impact fertility but that it is:

a) not just female education. It is also male education and equality between men and women in educational levels and

b) other elements combine with literacy.

Hence one cannot stretch too much statistical relationships or translate them too simplistically into policy, and into single thrusts into women alone.

NARRATIVE REPORT OF PLENARY PROCEEDINGS

Introduction: Reproductive Health Care

The meeting started with a brief introduction seeking to clarify the working definition of 'reproductive health' and to present the major objectives and agenda of the meeting.

The central objective of reproductive health programming is to enable women to

* regulate their own fertility effectively by conceiving when desired, terminating unwanted pregnancies, and by carrying wanted pregnancies to term
* remain free of disease, disability, or danger of death due to sexuality and reproduction
* bear and raise healthy children

To achieve the above objectives, a reproductive health care programme would have to be comprehensive, providing

- education on sexuality and hygiene
- education, screening and treatment for reproductive tract infections and gynaecological problems resulting from sexuality, age, multiple births and birth trauma
- counselling about sexuality, contraception, abortion, infertility, infection and disease
- infertility prevention and treatment
- choice among contraceptive methods, with systematic attention to contraceptive safety
- safe menstrual regulation and abortion for contraceptive failure or non-use
- prenatal care, supervised delivery and post-partum care (Germain and Ordway 1989)

To be effective, reproductive health programmes need to be sensitive to socioeconomic as well as gender dimensions of health problems. We need more than medical interventions to deal with them. Further, they have to be concerned with reproductive health problems arising throughout women's life cycle, from puberty through menopause and after. Reproductive health problems have to be understood within the context of women's general health and well-being, since they are interconnected. Clearly, women cannot have a good reproductive health status, unless they enjoy good overall health status as well.

Reproductive health is a vast subject area, but for the purpose of the present meeting, six main themes had been identified.

These were:

Maternal Health

Abortion

Reproductive Tract Infections

AIDS and HIV

Contraception

Following the introduction, each of these topics was introduced in the plenary by a team of two or three participants. Their presentation was based on their experiences, and focused on medico-social aspects of the issue as well as on a critique of existing policy. The participants then discussed the same topics in small working groups, to formulate policy and programme recommendations.

MATERNAL MORTALITY AND MORBIDITY

Maternal mortality is defined as the death of women during pregnancy, delivery or within 42 days post partum, from causes related to these, or from conditions aggravated owing to the pregnancy and delivery. The maternal mortality rate (MMR) in India is extremely high, and is estimated to be around 500 per 100,000 live births. Every year about 75000 to 1,00,000 women in the reproductive age group die due to causes related to pregnancy and child birth. About 75 percent of deaths are caused due to direct obstetric causes and 25 percent due to indirect obstetric causes such as anemia, hepatitis, violence, injuries etc Maternal morbidity owing to complications of pregnancy, child birth and puerperium are stated to be 15 to 16 times higher than maternal deaths.

There is a tendency to view maternal health in isolation of other women's health problems, and to plan narrowly focused health interventions to deal only with problems in pregnancy and birth. The fact that poverty and gender based discrimination causes women's health status to be very poor from infancy and childhood through adult life, and that many of the problems related to pregnancy and childbirth are related to this, is often overlooked.

Even within such a narrow approach, there is much more that needs to be done in the area of maternal health care. Even today, the vast majority of deliveries take place without trained attendance, and there is no post partum care to speak of. The clubbing together of maternal health care and family planning programme, has been responsible for its neglect, given the preoccupation of both planners and service providers, with population control. Women, due to their low social status, and lack of awareness and self esteem, and lack of decision making power, are not able to utilise even the limited services available. In India, social and cultural factors play a major role in the high maternal mortality and morbidity.

The subject "Maternal Mortality and Morbidity" was introduced in the plenary by three resource persons. These provided a critique of Maternal Health policy and experiences related to maternal health with special emphasis on social and cultural aspects.

Dr. Dilip Mavlankar, Assistant Professor, Public System Group, Indian Institute of Management, Ahmedabad, presented an analysis of the policy and programmes for Maternal Mortality and Morbidity and concerns related to it.

In his review of the Maternal and Child Health (MCH) policy in India he briefly touched on a history of policies. The Bhore committee (1946) specially focused on Maternal health care. From 1970s onwards the programme was linked with the Family Planning programme. He highlighted the fact that health policy document of 1983 includes only one paragraph on MCH, and that too, in relation to high birth rate and high infant mortality rate. The policy recommended a comprehensive programme for ante natal, intra natal and post natal care and continuation of the TBA training. It emphasised the need for maternal health services to reach the door step, with home deliveries being conducted by trained birth attendants, and timely referral of complications. More recently, MCH has been integrated into Child Survival and Safe Motherhood Progamme (CSSM) consisting of 11 components out of which 6 cater to mothers. One of the neglected aspect is that of referral of complicated cases.

Critiquing the programme, he said that while it has set itself ambitious goals, it does not have the infrastructural facilities to achieve it. The existing supply and maintenance of the facilities and the services was found to be weak and erratic. There is a large proportion of vacancies for personnel positions, and low motivation and lack of accountability characterises staff performance. Staff training programmes are usually one time efforts without ensuring timely follow up and emphasis on the theoretical aspects.

In addition, political interference leads to further delay in administrative procedures which accompanies poor management practices resulting in ineffective implementation of the programme at the village level. The monitoring of the programme is target based giving less importance to the quality of the programme.

The following were listed as the reasons for the low coverage and high maternal mortality and morbidity:

* Lack of awareness in the community regarding the services available.
* The community fails to perceive the benefit of preventive services.
* Services are not available, accessible or acceptable

- Poor quality of the services
- Maternal health is not considered a priority by the service providers as they have to accomplish unrealistic targets of sterilization for birth control.
- Low value accorded to women's health in the society
- Politically, administratively and even among the women's groups maternal health is accorded low priority
- Programmes are insensitive to women's need for privacy and empathy, especially as related to delivery care.

Dr. Vinaya Pendse, Gynaecologist and Obstetrician from a Udaipur hospital, presented an analysis of 929 maternal deaths amongst 1,11,153 deliveries conducted in the Udaipur hospital over the period of 1971-1993. This makes for a maternal mortality rate of 835 per 100,000 live births, a very high rate by all standards of comparison. Though hospital statistics do not reflect general mortality of a community (as it is bound to be higher due to high referral rate of high risk pregnancy cases and complicated cases), it does help in planning strategies for improvement of maternal health programme

While analysing the reasons of high maternal mortality (MMR) she mentioned that 70% of the Indian population lives in rural areas, where 85% deliveries are conducted at home, out of which only 33% are attended by trained personnel. In such a situation, childbirth complications are more likely to remain neglected and unattended. In rural areas where the MMR is high, the community also faces the additional problem of poor transport facilities, ignorance, illiteracy, lack of awareness and undernutrition.

Secondly the Government infrastructure in rural areas is usually under staffed and poorly equipped and the Government machinery at the rural panchayat level is not trained/competent to register MMR. Hence the problem remains underreported and invisible.

She highlighted that the problem of MMR is closely related to gender based discrimination in our society. In our social structure women are considered to be less important than men at all levels. Even in educated families, female children are considered an unwanted burden. Therefore to tackle the problem only from the medical angle does not suffice.

During her discussion, in addition to medical reasons she highlighted the different gender specific socio-economic and cultural factors that are responsible for the high maternal mortality and play a major role in causing maternal deaths, and the constraints that an obstetrician faces in the treatment of such cases.

About 60 - 65% maternal deaths in her hospital were avoidable, and could have been prevented. The majority of the cases were unregistered pregnancies (90%) and from rural areas (73%) and belonging to the poorer segment of the community.

About 38% women come to the hospital with the referral slip whereas 62% come directly which indicates the weak referral services at the rural level. Majority of women reach hospital very late and in a highly neglected condition (80%), about 32% of cases died within 4 hours of admission. Also they reached the hospital only when all efforts for a delivery at home had failed.

Women arrive at hospital (replete) with risk factors. They are often transported in filthy and unhygienic conditions, and arrive dirty. If the women need to be operated, initial preparation requires a lot of time leading to loss of precious time and making the case more complicated.

Taking patient history is a major step in case management, to aid in planning for reduction of MMR. Due to a number of reasons, this step becomes very difficult. The patient arrives at the hospital in a very serious condition, unconscious, semi conscious or is in agony. She is in no position to reply to the queries posed during history taking. Many a time, differences in language/dialect is also a barrier.

If the patient is accompanied by a male member of the family he is usually unaware about the history and the complication of the case. The TBA who has handled the case at the village level rarely accompanies the women and at times when she comes she remains "incognito". The medical staff is also prejudiced against the TBA, and considers her as someone who is responsible for the complication in the first place. Therefore her opinion is never asked. In such a situation, it is therefore very difficult to elicit accurate information like amount of loss of blood, extent of the force used to get the delivery done etc.

Many a times, incorrect history is given. In some cases at the hospital level if an inexperienced doctor is available incorrect case history misleads the doctor and the case gets further complicated. Often incomplete and incorrect information related to family size is provided, owing to the fear of being forced to accept sterilzation if they had more than two children.

Villagers who come for the first time to the hospital get frightened by the structure and the unsympathetic attitude of the hospital staff.

Many a times women come loaded with ornaments and in cases where the woman has a swelling on hands and legs it is very difficult to locate a vein for administration of an IV drip. At times the goldsmith has to be summoned to cut open the ornaments.

If the woman needs blood, the doctor faces other kinds of problems, as the family members are not usually willing to donate blood to women. A lot of time and energy is wasted in persuading the family members to donate blood.

Dr. Pendse had faced situations where the man had changed his identity from a husband to a neighbour just to avoid blood donation. At times when they are told that the woman will die if blood is not provided they are willing to let her die instead of donating blood. They are even ready to write frankly on a legal paper "Knowing fully well the consequences of maternal death of my wife I do not want to donate my blood. I take full responsibility" Often the women patient, if conscious, urges the doctor to let her die, but not to take blood donation from her husband or son.

Dr. Pendse also stressed that the family planning programme had drawn attention away from the important area of maternal health, which has resulted in lack of Government and public attention to the problem. Also the problem of the MMR has been grossly neglected by several womens' groups, perhaps because they want to dissociate from the image of women as mothers rather than persons.

She felt that doctors especially obstetricians also played a role in non-recognition or non-highlighting of the problem of Maternal Mortality because of their preoccupation with heavy load clinical work which is ever increasing in government hospitals. It is always discussed within the four walls of the hospital and how to prevent majority of the avoidable maternal deaths is never discussed in public.

Dr.D.K.Srinivasa, of the Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry in his presentation tried to highlight the socio-economic, cultural and institutional reasons related to maternal morbidity. His presentation was based on a study undertaken by his department under his leadership.

He reported that in his study the combined direct and indirect obstetric morbidity rate was 741/1000 pregnancies and the obstetric morbidity rate taking a select group of most common conditions, was 251/1000 pregnancies.

The major constraint he faced in his study of maternal morbidity was related to gender biases in the society. He mentioned about low social status, lack of self-esteem and religious restrictions constraining women. Lack of awareness about various morbidities arising from complications of maternity , and perceived in appropriateness of seeking care for 'personal' and women-specific conditions such as these, were other important constraints highlighted by his study. To emphasise how social factors influence maternal morbidity he presented excerpts from a few dialogues with women. Presenting a flow chart depicting a 24 year old women's modes of travel to reach a health facility for treatment, he clearly illustrated the many dimensions and severity of the problem. Lack of a suitable mode of transport, dependence on other persons, especially men, in the absence of public transport, to take her by cycle; the need for a companion to accompany her to the health facility for moral support- these were only some of her numerous problems. When analysed thus, it becomes far more than merely a 'transportation' problem.

Dr Srinivasa observed that very few women reported complications related to anaemia among the morbidities reported. This could be due to the fact that women were not able to perceive anemia as a serious complaint, and put up with poor health as their lot as women. He felt that women should be provided with necessary information related to health, and that they needed to develop their self esteem and understand that they have the right to be healthy. Assertiveness and empowerment training for women need to be organised to bring about a positive self-

image in women and alter their health seeking behaviour. Decision makers in the family also need to be oriented.

An interesting fact reported was that maternal mortality was nil in the JIPMER rural and urban health centre areas in the last few years and, despite this, maternal morbidity continue to occur. Thus, elimination of maternal morbidity does not automatically follow elimination of maternal mortality. Special efforts focused at maternal morbidity are needed.

He further felt that quality of services need to be improved and made more affordable. Another major effort that is required is to enhance political will by educating the political leaders and administrators to recognise Maternal Health as a major public health concern.

REPRODUCTIVE TRACT INFECTIONS

Reproductive Tract Infections (RTIs) are a major health concern for Indian women. RTI includes Sexually Transmitted Diseases (STDs), diseases due to overgrowth of organisms normally present in the genital tract, and other iatrogenic factors such as deliveries by untrained persons, illegal abortions and when proper aseptic precautions are not observed during gynecological procedures.

RTIs are a frequent problem for poor women, yet they often go undiagnosed and untreated. When left untreated, RTIs lead to complications such as ectopic pregnancies, cervical cancer and infertility. All RTIs are preventable and most (except viral ones) are curable. Despite this, they have not been accorded the priority they deserve by policy makers and donors, and services are practically unavailable at the community and health centre levels.

The subject of Reproductive Tract Infections was introduced by Dr. Sridhar, Sewa Rural, Jhagadia, Gujarat. His narrative drew from his field experience in working for women's health.

Dr Sridhar's talk touched on the consequences of RTIs and outlined suggestions for interventions. RTIs underlie 10-50% fetal wastage including abortions, still births, prematurity and growth retardation of foetus and 30 - 50 % prenatal infections. Both these consequences ultimately contribute to the high infant perinatal mortality rates. RTIs can lead to cervical cancer, AIDs, HIV, infertility (up to 70%), ectopic pregnancy, pelvic pain, backache, and dyspareunia. The short term and long term outcomes of RTIs can thus lead to medical complications, social ostracism and emotional distress.

Presenting the perceptions of women on RTI, he said that many rural women believed that RTIs are caused due to diet, or promiscuity; starts at puberty; and is spread through men. The white discharge is believed to originate from bones and spine.

He strongly felt that it is necessary to consider socio-cultural dimensions of RTIs both for prevention as well as for the treatment.

He suggested timely treatment, primary prevention and operational research at the level of interventions. In rural areas he felt that the prevention and treatment can be integrated at the level of existing Primary Health Care (PHC).

A lively discussion followed Dr Sridhar's presentation. Some of the points made were as follows:

- The incidence of STDs has increased at a rapid rate during the last few decades because young people have become more sexually active.
- Poor economic status leading to migration often forces couple to prolonged separations, leading to unsafe sexual practices which would contribute to an increase in STDs.
- Increased sexual abuses, and sexual violence leads to increased incidence of sexually transmitted RTIs.
- To some extent, the problem of RTIs is further aggravated due to poor menstrual hygiene.
- Neglect of asepsis in gynaecological and obstetric procedures is another common route for RTIs. Given the poor quality of services in family planning, IUD insertion is most commonly associated with the incidence and/or aggravation of RTIs.
- Fear of exposure and embarrassment is a major deterrant to seeking STD treatment. In addition, treatment is

often very expensive. Being related to sexual behavior it is also very difficult to assess and suggest behavioural changes to prevent recurrance of the disease/infection.

- RTIs get low priority in policies and programmes because they are not considered fatal. It was also felt that RTIs are often thought to lead to stigmatization of Family planning programme and are therefore given low priority.
- Women are found to be more vulnerable to RTIs because they are extremely powerless in the Indian social and cultural context and lack negotiating skills in their sexual lives both within and outside marriage. Thus, they have no control over their partner's unsafe sexual behaviour, and no power to refuse sexual relations with him.
- The present social structure does not provide women with an enabling environment and privacy to facilitate positive health seeking behaviour for RTIs especially those sexually transmitted. This leads to delayed identification, misery, pain and further complications.
- Women also suffer more serious social consequences arising from untreated RTIs. The problem of infertility often leads to marital violence and abandonment of women. RTIs observed among prostitutes is another neglected area and they are always blamed for the spread of the disease.
- RTIs as a problem do not get priority in the existing health programmes due to lack of gender sensitivity among health planners and policy makers, medical professionals and para medical staff.

HIV/AIDS

It is now widely recognized that HIV/AIDS has assumed the status and dimensions of an epidemic in many parts of World. WHO has estimated that by the end of 1991, about 1 to 4 lakhs persons in India were likely to be HIV positive. 310 AIDS cases have been reported in India up to March 1993. Of all persons suffering from AIDS, one third are women. Biologically, women are ten to thirty times more prone to AIDS infection at any given contact due to a larger exposed surface of virus penetrable membrane.

The subject of HIV/AIDS was introduced to the participants by Ms.Geetha Sethi, Consultant, National AIDS Control Organisation (NACO) and Ms. Parbeen Singh, Free Lance Consultant.

Ms. Geetha Sethi in her presentation outlined the present status of HIV infections/AIDS in India. She mentioned that the AIDs programme has been integrated with the existing health care programmes (in response to which several participants raised doubts about its validity in practice).

The NACO has in addition, taken various steps for the prevention and control of HIV infection. Guidelines have already been issued by the Ministry of Health regarding blood transfusion, and rational use of blood. STD services were being strengthened, as these are high risk groups for HIV infection.

Women, particularly those who are illiterate and from rural areas have poor access to information and more vulnerable to HIV infection, for much the same reasons as in the case of RTIs. They are also in danger of infection through blood transfusion for obstetric emergencies. At present, the only way in which a woman can protect herself from infection is through negotiating condom use by her sexual partner, a difficult proposition considering how little say they have over their partner's sexual behaviour. The female condom may be a better alternative but it has not yet been introduced in the country.

For prevention of AIDS, sex education is an effective strategy and can be imparted both to adolescent boys and girls at school and integrated in the college curriculum. Special educational programmes can also be organised at tourist sites, railway stations and for armed forces. This can be done through the collaborative efforts of NGOs and GOs.

Ms. Parbeen Singh in her presentation emphasized on the gender dimensions of HIV/AIDS infection, focusing on the following points :

Biologically, women are more prone to AIDS infection and combination of gender based discrimination and a low socio-economic status again makes women more vulnerable to infection than men. She felt that these two points are not given due attention in policy formulations and implementation of programmes. Unlike men, who when provided with information and means are able to protect themselves from sexual and drug misuse and infection, women are not socially and culturally empowered to do so. Even if they have the knowledge about safe

sex practices and drug use, their lack of autonomy does not allow them to take decisions that concern their own lives and bodies.

Men's mobility and the fact that they often have to spend several days away from home, makes them seek sexual fulfilment elsewhere which exposes them to a high risk of infection which in turn is passed to their wives or other women with whom they have sexual contact.

It is an established fact, that most infected women become infected during sexual intercourse with their husbands and regular male partners. Therefore the responsibility for prevention needs to be shared by men and women rather than shouldered by women alone. For example, instead of asking women to 'negotiate' for condom use with their partners, there needs to be greater emphasis on the use of condoms by men on their own accord.

Men must learn to respect and accept women as being equal partners in all activities that concern both of them. Mutual respect and trust, open and honest communication about sexuality and sexual behaviour can prevent the transmission of sexually transmitted diseases and AIDS. She suggested that women need to be organised so that they work together to be empowered to demand their rights. Women's organisations and committed people working in the area of social and economic upliftment as well as human rights can extend valuable support to organise women in the fight against AIDS.

ABORTION

Abortion related morbidity and mortality is a serious concern in India. It is estimated that about 65 lakhs abortions take place every year in the country, out of which 25 lakhs are estimated to be spontaneous (natural) and the rest (about 40 lakhs) induced. A large proportion of induced abortions are illegal, induced by unqualified persons and/or women themselves. Such illegal abortions are associated with extremely high risks which may result in serious complications or deaths. About 12% of maternal mortality is due to abortion alone.

That illegal abortions take a high toll of lives in our country despite having provisions for legally terminating a pregnancy calls for a need to examine the underlying causes in detail and rectify these.

The topics were introduced to the participants by Ms. Sudha Tewari, Managing Director of Parivar Seva Santha and Ms. Rami Chhabra, Free-lance Consultant. The topic could not be discussed at length in the small group due to lack of time. The details of plenary discussion are given.

Ms. Sudha Tiwari presented the overview of the problem of abortion. She highlighted that while an estimated 11.2 million abortions take place in the country every year, only 6.7 million have been officially reported. There seems to be a high rate of unreported abortions. The present abortion rate is 452 per 1000 live births. She briefly mentioned about the MTP act, availability of the MTP services, and training of the medical personnel.

Based on data from Parivar Seva Sanstha's clinics, she discussed the knowledge and attitude of the clients, providers and policy makers. Knowledge about induced abortions was 75.8%, while awareness about provision of legal abortion was 36.5%. Knowledge of availability of MTP services at PHC was 46.5% She mentioned that even though there is social stigma attached to induced abortions, 2 out of every 10 women would have at least one abortion in their entire life span.

While discussing the experience of Parivar Seva Sanstha (PSS) she informed that PSS had performed 51433 abortions in 1993 which contributed to 8:6% of total reported MTPs in India. The PSS has, through its contribution to providing high quality abortion services, been able to highlight the unmet need for MTPs, and have had a catalytic effect on quality, availability and cost of MTP services, and had to some extent reduced the incidence of backstreet abortions. The PSS have been able to set standards of quality services, counselling, medical skill and client care. While elaborating on the counselling she highlighted that they perform it before and after abortion, and also motivate abortion seekers for family planning acceptance. The positive experience of PSS could serve to inform improvements and changes in the government's health services, and MTP centres in the public health services could be encouraged to adhere to the same set of standards in service delivery, provision of information and counselling.

Ms.Rami Chhabra's presentation drew on a review of abortion studies and data, recently completed by her.

Data indicates that official figures for MTP have increased from 0.278 million in 1976 - 77 to 0.632 million in 1991 - 1992, an increase of 8.49 percent per year. The number of approved centres for MTP have also increased from 2149 in 1976 - 77 to 7121 in the corresponding period showing an increase of about 15.42 per cent per annum. Comparing the two trends, it is evident that the performance of MTP has not kept pace with the expanding network of MTP centres. It seems likely that at least twice as many MTPs are being conducted by qualified physicians in recognised facilities, as are reported. Cumbersome reporting procedures are a major deterrent.

MTP facilities are still grossly inadequate as compared to the estimated need. Most MTP facilities are urban, and only 1800 out of over 20,000 PHCs provide MTP services. While women prefer qualified physicians and approved institutions, poor knowledge of such facilities, poor accessibility, as well as general dissatisfaction with public facilities owing to lack of privacy, courtesy, and lack of compassionate interaction by service providers, drives them to the private sector. The private sector consists of qualified and registered services, facilities with qualified personnel but unlicensed, and unqualified personnel. It is the last category that dominates service provision, contributing to serious complications and high mortality.

As for issues related to licensing of health facilities for performance of medical termination of pregnancy, the MTP (Amendment) Rules 1977 which are presently applicable specify that the experience or training required for medical practitioner to qualify for registration to undertake MTP procedures is less than 3 years of practice as obstetrician/gynaecologist, or at least one year of hospital-based experience or performance of at least 25 MTPs. If undertaken by anyone without the requisite qualifications, the procedure is considered criminal. However, there is a serious shortage of trained personnel to perform MTPs. It may be worthwhile re-examining these licensing requirements, and training paramedical personnel to perform menstrual regulation in the early stages of pregnancy, to improve access to timely pregnancy terminations.

In conclusion, she stated that the MTP programme was in a dismal state, and needed critical attention for streamlining of service delivery; and more critically still, must acquire a vision beyond a 'supplies and techniques' scheme.

In the brief plenary discussion which followed, some important points were raised:

* The MTP Act, although liberal to the extent that it provides scope for legal abortions, still vests the power to make decisions regarding whether or not to provide abortions, with the medical profession. This should change, and abortion should be made available on demand to women.

* Inflexibilities in the Family Welfare Programme, such as not offering temporary methods to women with two or more children, lead to unwanted pregnancies and abortions in women who are not yet ready to accept permanent methods of birth control.

* The practice of insisting that women with two or more children should accept sterilisation when seeking MTP, causes many women to turn to illegal abortions.

* Women's lack of awareness and access to MTP facilities is a consequence of women's powerlessness in a patriarchal social structure.

* Selective abortion of female foetuses was a tricky issue in the context of acknowledging women's right to abortion. The only approach to dealing with it effectively was long-term, and centred around improving women's status and empowering them, to deter devaluation of daughters.

CONTRACEPTION

The Government of India recognized the need for population control and was the first in the world to launch a family planning programme in the year 1952. It has adopted various strategies over the past four decades principally to bring about fertility decline, and has been driven by demographic goals. Far from meeting women's need for fertility control, it treats women as the perpetrators of the 'population problem' , and exhorts them to stop reproducing through a combination of carrot-and-stick policies. In order to further accelerate the rate of fertility decline, the programme is now planning to introduce several new high-tech contraceptives, for some of which clinical trials are now under way. Numerous controversies surround the subject of family planning and contraception, and it is a major women's health concern especially in the context of being delivered through a population-control programme.

The subject was introduced to the participants by Dr. Pramila David Director, Centre of Population Concerns and Dr. Mira Shiva. HOD, Public Policy, Voluntary Health Association of India.

Dr.Pramila David presented a critique of the programme. According to her, any analysis of policy has to go beyond its pronouncement and look into to what it achieves the operational level.

Some of the assumptions that have influenced family planning goals and the direction of the programme have been, that:

* Goals driven by demographic concerns could influence human behaviour, that too in an area as complex and personal as contraception.

* Young men and women in this country irrespective of their socio cultural and economic status or rural/urban divide would control their fertility if provided with technically feasible and modern contraceptives.

* Centrally planned targets will be achieved as directed, irrespective of the contraceptive needs of a given community.

* Service providers, medical officers and paramedical staff at the field level administrators would be able to provide the much needed services after brief training on the technological aspects.

* Money incentives to the acceptors would bring both, enable greater acceptance and help the programme in achieving its targets. A combination of threats and incentives to service providers would bring about desired results.

* In events when achievements fall short of set targets " Camp approach" could be instituted with a view to achieve the targets; and/or incentives further enhanced.

* When a particular method of contraception fails, replacing it with newer methods would solve the problem, irrespective of the reasons why the earlier method failed.

* Younger couples can be made to accept spacing methods because of its demographic impact.

These assumptions indicate how the policies have been formulated, and goals were established. It also explains the responses of the people to the programme at the implementation level. It also indicates the kind of managerial, marketing and administrative sense had gone into the design and redesign of the programme in the past.

She emphasised the importance of learning from past mistakes. To convert a complex human phenomenon ie. population growth and its potential into a game of numbers has been one of the programmes biggest mistakes. Women cannot be called upon to fulfil a national need, unless it happens to be their own need as well, especially in a democratic set up such as ours. Today, women would like their partners to take equal responsibility in birth control. Concerted efforts at the programme level are required to increase male responsibility for birth control.

Other limitations quoted by her were that the contraceptive services provided till the date have demonstrated a total lack of care and concern for the larger well being of the client. Such being the experience of a large proportion of acceptors, many other potential users hesitate to accept any form of contraception, and may resort to MTP.

Any welfare service, if provided out of context to its natural environment, in other words, contraceptive services provided without reference to its origin i.e. sexual or reproductive health care will erode the professional

ethics and dignity of the service providers thereby lowering the morale and motivation of all those who are providing services. They are made to function in an environment which is distasteful to them. Currently a two way negative cycle has been created wherein both the programme personnel and potential client are rejecting the programme.

She emphasized that in order to succeed, the family planning programme needs to be reviewed and redesigned so that the policies, programmes, administrative procedures and evaluation criteria are more people centred. In a nut shell, a change in the thinking of the policy planners and programmers is to be ensured.

She recommended the following :

* Create conditions and environment to prepare the client groups through education, social action, and a broad range of health care services so that the client would seek reproductive health care for her/his own benefits.
* Provide a range of contraceptive choices and assistance to clients to choose with care the contraceptive that is best suited to them. In fact, this can be enabled by trained medico social workers.
* Individual check lists to be prepared and made available to all those who request contraception and to be enlightened regarding the screening procedures, suitability, effectiveness, side effects and complications of each contraceptive.
* Provide quality services with care and competence. Follow up regularly with aftercare services to keep the contraception acceptor satisfied. Take full moral responsibility for the after effect of services.
* Targets to be prepared by the field personnel with client participation. Total range of reproductive health care services in each village to be planned and a plan of action for each type of service to be prepared.
* Abolish centrally planned targets, incentives and camp approaches.
* Change evaluation indicators to include women's gynaecological concerns and quality of services.
* Allocate adequate resources for physical amenities, and trained human resources.
* External monitoring and evaluation of government programmes to be introduced.

Dr. Mira Shiva approached contraception from the point of view of Primary Health Care Provider, Rational Drug Use, as well as Women's Health advocate.

Policies related to contraception have continued to be centre stage for several decades now, specifically in third world countries, with only terminologies changing, from maternal and child health care to safe motherhood to reproductive health. Contraception has received priority in planning, budget allocation, research and even provision of services. In spite of this, contraceptive needs of women are not adequately met and policy planners feel dissatisfied as the desired performance in demograhic terms has not been achieved.

This preoccupation with implementing population control policies has caused deep concern among health personnel who subscribe to the concept of primary health care, holistic health and rational drug use. Such a preoccupation is unfortunate, because it has resulted in the neglect of other health services. It was not women's contraceptive and health needs that guided the policies but demographical goals for reducing population growth rates and fertility rates. Had the finances used for incentives and organizing camps been used to strengthen primary health care centres, which would provide contraceptive services as part of general health services and not in place of it, women would have had access to reproductive health care. Population control has caused planners and service providers to turn a blind eye and a deaf ear to the genuine needs of women.

Even in the case of medical education and training of health workers, while subjects such as population explosion, and different contraceptive methods is introduced, never discussed are issues related to women's powerlessness in decision making about their own reproductive lives, the worsening of the inverse sex ratio, women's solitary shouldering of the responsibilities of conception, contraception and child care.

In demographically driven population control programmes, women are treated merely as numbers. If due importance were given to issues beyond contraceptive technology: e.g. female literacy, women's social, economic and political status, property rights, employment and basic minimum wages, meeting basic needs for food, shelter,

education and health care to ensure child survival, it could have made a tremendous contribution to voluntary reduction of family size.

It is clearly known that it is the fulfilment of several basic needs and improvements in child survival that has led to decrease in birth rate in many countries. Focusing on contraception when the former is getting eroded will not help.

Over-population is considered as a cause of poverty and environmental degradation. By so defining the causes of poverty, attention is shifted from the real problem: increasing unequal distribution of resources and opportunity, power and control. The situation has become worse with the new economic order. In India in those states where a large number of poor live, where social status of women is low, there has been a worsening of adverse sex ratio, female foeticide and dowry deaths. Where female literacy is low, women have poor access to education, health care and income generation, birth rates and maternal mortality are higher.

We find an unnatural concern for women's unmet needs on the part of policy makers. However, these are not defined in the context of women's unmet health needs but only in context of "unmet contraceptive needs". No one is talking about unmet needs in the area of food, clothing and shelter and basic amenities. This concern for unmet needs is ironic especially at the present juncture when the conditionalities imposed by international financial institutions have cut funding to the social sectors. One important area negatively affected is the public distribution system (PDS), which has resulted in increase of food prices. In the present social set-up, women's health would be most adversely affected. One can well imagine the consequences, when over 70% of pregnant women are anaemic as it is.

Another grossly misused term is 'widening choice'. These 'choices' for women are being considered merely in context of contraceptive technology but little consideration is given to choices which would provide options for improvement in work, income, education, and access to better living conditions; options to come out of oppressive, degrading, violent, marriages, and so on.

In spite of use of the terms Family Planning, Family Welfare and Population policies, the focus has always been on increasing the use of contraceptive methods and development of invasive, long acting, provider controlled, expensive contraceptive technologies. Each new contraceptive technology, when first introduced was greeted as the ultimate in successfully dealing with the "population bomb". The reality is that the targeted population for the programme was mostly poor women, who are considered as ignorant and irresponsible, and not able to control their fertility. Their participation in the family planning programme meant unquestioning acceptance of the recommended method.

The attitude of family planning programme/peripheral health worker is target oriented. If serious attempts would have been made to upgrade health services so as to ensure basic health needs specially for women's health problems, the need for newer invasive hormonal contraceptives targeted at women ,would have been much lower.

However, when faced with difficulties in acceptance of family planning by women, the programme sought to find an easy way out through introduction of newer technologies which would demand even better health infrastructural facilities. What is needed is addressing the basic problems with respect to provision of contraceptive services, especially those related to screening for contraindications and managing/treating problems thus detected, For example, there is absence of adequate diagnostic and therapeutic facilities to diagnose and manage gynaecological infection prior to inserting IUDs. Inserting an IUD in a women suffering from gynaecological infection without adequate treatment is not only unethical but also "bad medical practice".

Contraception means being able to prevent conception, either naturally, through periodic abstinence, or through the choice of contraceptives which may be short acting or long acting. Abstinence which has been part of Indian cultural ethos, whereby on certain days, and for a certain period after delivery etc. couples were expected not to cohabit. During Brahmacharya- the period of youth before marriage- it was expected that sexual urges and sexual energies would be controlled.

Opting for a technological solution to the issue of fertility control, in a mechanistic way, is far from empowering. Fertility awareness- the knowledge that a woman is fertile only during a specific period during her menstrual cycle, and about how to identify this period - and periodic abstinence during the fertile period, requires

the participation of both partners, and can be a good option for many. However, a study by the Planning Commission showed that only 2% of couples knew about the fertile period. Such natural methods have been systematically marginalised and invalidated in the technology-driven approach to fertility control adopted by the Indian family Planning Programme.

The Indian programme treats fertility control as the sole responsibility of women, and targets its messages and services almost exclusively at them. There is clear evidence of decreasing male responsibility in these matters and increasing sexual exploitation of women. An example of this is that while newer contraceptives are researched on women, an increasing variety of potency drugs for men are flooding the market.

If some proportion of the money and time spent on trying to get women to accept sterilization, could have gone in convincing the men for accepting vasectomy by removing fear of impotence, the men would have understood their role in family planning and need for male responsibility.

Acceptance of the fact that men have greater uncontrolled sexual urges which must be met either by wife, mistress or commercial sex workers, means the acceptance of a male dominated view to sexuality. Large number of women are impregnated against their will, inflicted with STDs & HIV/AIDS against their will from their partners whom they care for and trust. The issue is not merely of "Safe Sex" but of taking responsibility. The condom is used by the male partner for his own safety to prevent him from getting infected from a commercial sex worker. He does not feel the need for use of condom to protect his wife even if he has had multiple partners. Even when it is known that a large number of men have extra marital exposure, contraceptives are basically pushed on women.

Contraceptive methods most used during the past decades have been female sterilization and the IUD. Many women once assured that their babies will survive, decide to complete their families earlier with terminal method, not only because there is no worry of pregnancy afterwards, but also because of the luring money incentive provided

The camp approach where numerous sterilizations especially female sterilization (with laparoscopy) are done is not only associated with unhygienic conditions, lack of aseptic conditions/procedures but has also resulted in systematic erosion of the PHC facility, facilities and undermined follow up and accountability.

Laparoscopic tubectomy could be a very good procedure if proper examination is done and the operation is not performed in a hurry. However, targets and their fulfilment at the end of financial year February-March have been associated with numerous complications and problems. The denial of the existence of these facts and attempts to cover up have led to perpetuating greater carelessness and less accountability. It goes without saying that voluntarily sought sterilization, done with proper preparation, aseptically with adequate follow-up is a genuine need of many women who have completed their families.

Newer hormonal contraceptives like Norplant, Net En, Depo-provera are long acting, invasive and provider controlled. They are all associated with side effects such as cancer, the disturbance of menstruation, amenorrhea, frequent bleeding and spotting. In several societies menstrual bleeding can create problems as it interfaces with praying, fasting, sexual intercourse and women's feeling of health and well being. Other side effects reported are headache, weight gain, dizziness, abdominal discomfort, mood changes, loss of libido and osteoporosis. Apart from this there is always possible to abuse the injectable, giving it to women without their knowledge that it is a contraceptive. Further, clinical trials for some of these contraceptives were being conducted unethically, recruiting lactating and other non-eligible women, often without adequate informed consent. The results of these trails were rarely made available to the public, especially in cases where trials are suddenly discontinued due to questions about method safety.

It is because of such concerns about the new hormonal contraceptives that several women's organisations had gone to court in India against the clinical trials for NET-EN, and were opposing the introduction of Depo-Provera and NORPLANT.

In conclusion she highlighted :

* Rational contraceptive care is an integral part of women's health care and primary health care. Improvement of the latter is to be given the highest priority to ensure quality.

* Ensuring basic health services for survival and development of children, and basic educational facilities for

primary education is a precondition for effective fertility control, so that mothers are not forced to have more children.

* Efforts at empowering women and ensuring socio-economic, political, demographic, legal and human rights, which provides opportunities for genuine development would greatly enhance women's control over decisions related to reproduction. Instead of being viewed as mothers and baby-makers, women's choice to remain single must become socially acceptable, and they should be able to opt out of marriage with sense of security and dignity. Acceptance of adoption of babies by single parents must be made. Social expectations from daughters need to be changed, and it should be acknowledged that daughters as much as sons, can be an asset and can take care of parents in their old age; they are not merely 'dowry needers'.

* External population control pressures, which distort contraceptive uses by forcing 'targets' and incentives must stop, especially as a part of conditionality for loans.

* Targeting women in Family planning programmes must stop and a genuine effort made at encouraging male responsibility.

* Fulfilling women's basic socio-economic needs would need to be a pre-requisite, or at least accompany efforts to meet women's contraceptive needs.

* Unbiased information related to contraindications and potential side effects of all contraceptives needs to be made available.

* Monitoring of service delivery, especially the assurance of free and informed choice, and the absence of any form of overt or covert coercion must be done by independent bodies, which should also look into complaints and deals with issues of accountability of service providers and compensation for clients.

* The equation by policy makers, of 'Contraception' with use of costly contraceptive technology needs to be questioned and challenged. Efforts should be made at creating awareness about safe periods.

* Potentially hazardous technology e.g. injectable and implants should not be introduced into the country or in the family planning programme, especially in the absence of adequate health care services.

CLOSURE OF THE MEETING

January 24-28 1994 Rio de Janeiro

THE RIO STATEMENT OF "REPRODUCTIVE HEALTH AND JUSTICE: INTERNATIONAL WOMEN'S HEALTH CONFERENCE FOR CAIRO 1994"

During the period January 24-28, 1994, 227 women from 79 countries participated in "Reproductive Health and Justice: International Women's Health Conference for Cairo '94" held in Rio de Janeiro. The conference brought together representatives of women's and other non-governmental organizations and networks active in the fields of health, human rights, development, environment, and population. The main objective of the conference was for women to prepare to participate in the International Conference on Population and Development to be held in Cairo in September 1994, and to provide a forum where women could search for and identify commonalities on reproductive health and justice, while recognizing the diversities emanating from different economic, social, political and cultural backgrounds. The conference also aimed at developing tools and strategies to be used before, during and after the Cairo conference.

The participants strongly voiced their opposition to population policies intended to control the fertility of women and that do not address their basic right to secure livelihood, freedom from poverty and oppression, or do not respect their rights to free informed choice or to adequate health care; that whether such policies are pro- or anti-natalist, they are often coercive, treat women as objects not subjects, and that in the context of such policies, low fertility does not result in alleviation of poverty. In fact, a significant number of the participants opposed population policies as being inherently coercive. There was unanimous opposition to designing fertility control measures or population policies specifically targeted at Southern countries, indigenous peoples or marginalized groups within both Southern and Northern countries, whether by race, class, ethnicity, religion, or other basis.

There was also significant criticism of pressure by donors and efforts to link development aid or structural adjustment programs to the institution and/or implementation of population control policies and a suggestion that donor countries should not promote in other countries what they do not support for the majority of their own people.

It was agreed that:

1. Inequitable development models and strategies constitute the underlying basis of growing poverty and marginalization of women, environmental degradation, growing numbers of migrants and refugees, and the rise of fundamentalism everywhere. For women, these problems (and their presumed solutions through economic

programs for structural adjustment which promote export production at the expense of local needs) have particularly severe consequences:

- growing work-burdens and responsibilities (whether in female-headed households or otherwise);

- spiraling prices and worsened access to food, education, health services and other basic rights;

- greater economic pressures to earn incomes;

- growing victimization through violence, wars, and fundamentalist attempts to control and subordinate women sexually and in a number of other ways.

2. External debt, structural adjustment programs, and international terms of trade sustain Northern domination, increase inequalities between rich and poor in all countries, aggravate civil strife, encourage the corruption of government leaders, and erode the already meager resources for basic services.

3. Environmental degradation was seen to be closely related to inequality in resources and consumption, profit/driven production systems, and the role of the military as a major polluter and user of resources; hence, there is a close relationship between the violence and poverty that bedevil people's, particularly women's, lives and environmental problems. Focussing on women's fertility as a major cause of the current environmental crisis diverts attention from root causes including exploitative economic systems, unsustainable elite consumption patterns and militarism. Women in the conference urged governments to diminish military expenditures in favor of social programs. The participants also urged the Northern governments and donors to stop supporting and financing military and undemocratic regimes in the South.

4. There was particular concern about the situation of women migrants who are heads of households, domestic servants, migrant workers, entertainers and other service workers. It was agreed that while the movement of people should not be constrained by discriminatory and restrictive immigration policies which operate in contexts where migration is often forced by economic hardship, civil strife, war and political persecution, efforts should be made to address the brutality and violence faced by women and children who are victims of trafficking and sexual exploitation.

5. Alternative development strategies must be identified. In doing so, there is no single blueprint for development strategies but a multiplicity of approaches within a basic framework of food security, adequate employment and incomes, and good quality basic services which can be guaranteed through democratic people-centered and participatory processes.

6. The "sustainable and human development models" that are currently being proposed in the official documents of governments and international organizations, need to be based on investments and social policies that guarantee the quality of life and well-being of all people.

7. There was general agreement on the need to design social development policies starting from the concerns and priorities of women. These include:

- the need to redistribute resources in an equitable and just manner without discrimination against women, to remove poverty, and to improve the quality of life of all;

- the need to design development strategies so that they do not disempower and marginalize people, particularly women;

- to restore and strengthen basic services (for health, education, housing, etc.) that have been eroded by macroeconomic policies;

- to provide health services that are of good quality, accessible, comprehensive, and address the reproductive health needs of women and men of all ages;

- to address reproductive health and rights needs and concerns (including the right to free and informed choice) within the context of social and economic justice;

- to strengthen women's participation and empowerment in political and policy-making processes and institutions with the goal of achieving gender balance in all such processes and institutions;

- to build accountability processes and mechanisms into policies.

8. The discussion of fundamentalism brought strong agreement that, whatever its origins or religious claims, its aim is political. Central to fundamentalist attempts to gain political power is the control of women's lives and in particular of female sexuality, including the right to self-determination and reproductive decisions. There was criticism of the role of major Northern countries in supporting fundamentalist groups for their own political ends. Fundamentalists use religion, culture, and ethnicity in their pursuit of power; such movements represent a new form of war against women and an aggressive attempt to mutilate their human rights.

9. A major site of the fundamentalist war against women is over the meaning of "families". The participants at the conference agreed that a definition of family which is limited to a model with a male "head" of household, wife and children, does not reflect the life situation of all of the world's people. Instead it was agreed that all those who voluntarily come together and

define themselves as a family, accepting a commitment to each other's well being, should be respected, supported, and affirmed as such.

10. All members of the family have rights, especially to justice and human dignity. Physical, emotional, psychological or sexual abuse towards women, young girls and children within families constitute a serious violation of basic human rights under the Universal Declaration of Human Rights. Women's rights within the family include access to resources, participation in decision making, bodily integrity and security. Women have a right to participate in public life, to social benefits and social insurance, and to have their unpaid work inside and outside the home recognized and share by all members of the family.

11. Comprehensive and high quality health services for women, including for reproductive health, are a primary responsibility of governments. They should be available, accessible and affordable to women in order to reduce maternal mortality, morbidity, child mortality and unsafe abortion, within a broad women's health approach that addresses women's needs across the life cycle. Qualitative (as well as quantitative) indicators need to be developed to assess services, and users need to be involved in this.

12. There was clear agreement that quality reproductive health services are a key right for women. However, existing family planning programs cannot simply be redefined as programs of reproductive health. Reproductive health services should include prenatal, childbirth and postpartum care including nutritional and lactation programs; safe contraception and safe non-compulsory abortion; prevention, early diagnosis and treatment of sexually transmitted diseases, and breast, cervical and other women's cancers as well as the prevention and treatment of HIV/AIDS, and treatment of infertility; all with the informed consent of women. These services should be women- centered and women-controlled and every effort should be made to prevent the maltreatment and abuse of women users by the medical staff. The UN and other donors and governments should recognize the right to safe and legal abortion as an intrinsic part of women's rights, and governments should change legislation and implement policies to reflect such a recognition.

13. In the area of contraceptive technology, resources should be redirected from provider-controlled and potentially high risk methods, like the vaccine, to barrier methods. A significant proportion of the participants also felt strongly that Norplant or other long-term hormonal contraceptives should be explicitly mentioned as high-risk methods from which resources should be redirected. Female controlled methods that provide both contraception and protection from sexually transmitted diseases, including HIV, as well as male methods, should receive the highest priority in contraceptive research and development. Women's organizations are entitled to independently monitor contraceptive trials and ensure women's free informed consent to

enter the trial. Trial results must be available for women's organizations at the different stages of such trials, including the very early stages.

14. Better health services are one element of women's human rights. In addition, sexuality and gender power relationships must be addressed as a central aspect of reproductive rights. Reproductive rights are inalienable human rights which are inseparable from other basic rights such as the right to food, shelter, health, security, livelihood, education and political empowerment. Therefore, the design and implementation of policies affecting reproductive rights and health should conform to international human rights standards.

15. Women are entitled to bodily integrity. Within this principle, violence against women; forced early marriage; and harmful practices, especially female genital mutilation, must be recognized as a major reproductive rights, health and development issue. Governments should take measures to combat such practices and should be held accountable for failure to do so.

16. Women have a right to express their sexuality with pleasure and without fear of abuse and risk of diseases or discrimination on the basis of their sexual orientation or disability. Social and economic powerlessness; oppressive cultural, traditional and religious norms and practices; inequitable laws; fundamentalism and fear of male violence are impediments to women's own sense of entitlement and should be challenged.

17. Women, especially girls, must have equal access to education in general. Such education should not be gender discriminatory in its objectives, methods and content. Quality sex education with a gender perspective should be made available to women and men of all ages, in order to create the conditions for equity in social roles and empowerment of women in order to enable them to control their own fertility.

18. For women to be able to empower themselves and fully exercise their rights of citizenship, the underlying inequities in gender relationships must be eliminated. In particular, policies and programs should educate and encourage men to share family responsibilities, including the responsibility for their reproductive behavior and for the prevention of STDs.

19. Participants at the conference were concerned that women and women's organizations should be involved in the decision making process locally, nationally and internationally where any laws or policies affecting their rights and health are designed and implemented. Governments, the UN, and other international institutions should be held accountable for the design and implementation of social and development policies that guarantee women's reproductive rights and health. Mechanisms for monitoring and regular evaluation should be established, and should provide for participation of women's organizations.

20. Donors and governments should also be held accountable and their concern for women's health and development should be reflected in their resource allocation and priorities. Donors and governments should revise their funding categories so as to promote comprehensive women's health programs, rather than narrowly defined programs for family planning. A major requirement is that women-centered programs must have access to a fair share of the financial resources available for reproductive health.

21. The participants recommended a UN commission on women's reproductive rights whose composition should be gender balanced, and should take account of geographic, ethnic, racial and other balances. The said commission should be interdisciplinary and should include NGOs, especially women's human rights organizations. Each government should be held responsible to establish a similar commission at the national level.

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PRESENTATION BY SWATIJA FOR FORUM FOR WOMEN'S HEALTH
At Medico Friend Circle Annual Meet on Reproductive Health

held at Sevagram 13 - 15 January 1994

Medico Friend Circle has taken issues of women and health at all levels. It may be campaigns like high does estrogen and progesterone preparations or injectable hormonal contraceptives. Bhopal has also remained one of the major concerns of MFC. There have been continuous inputs coming from MFC to various campaigns like sex-determination, long-acting contraceptives etc. But to have a meeting on reproductive health is welcome step ahead.

At this initial presentation I would like to put before you some thoughts on how reproductive health has been looked at, and at the same time in what ways has this view been challenged. What I shall speak will surely not be new for most of you. I as a representative of FFWH am putting here before you facts and ideas that have emerged from all our work for the last so many years. This work is the legacy of all of us present here. It is just an effort at a recapitulation, at putting everything together so that we begin the deliberations of the next few days starting from a common ground and hope to move ahead together.

Generally it is important to identify what one means by reproductive health. As we all know biology constructs societal norms and it has been a major force in constructing man woman relationship. At the same time reproduction may be a biological phenomena but it is very much a social construct. So any understanding of reproductive health would have to move between these two arenas of all our lives.

In fact, when talking of reproduction, the first that comes to one's mind is women's fertility cycle. This has remained an issue of awe at times and has also acted as identification with nature and other natural cycles. Old cave paintings depicting menstrual cycles have been found in almost all ancient civilizations. Fertility has been understood in different ways. The different remnants of fertility rites still exist in our culture and menstruation remained a taboo. It is looked upon as dirty and inauspicious by society. The identity of woman and change in her personality after menstruation is a well studied social issue. Puberty of men and the changes in their own bodies and creation of a myth of manhood also happens at about the same age but this area has remained unexplored. We feel when we are talking about reproductive health we must really talk about these aspects of woman and man., how their physiological body changes affect their person. Physical existence constructs their respective personalities. Here we want to emphasize this point because identifying reproduction as women's responsibility is a social construct. We want to identify reproductive health by identifying it with both men and women.

When we say that physical existence also constructs persons, this division along sex becomes very important. So also does expression of one's sexuality get dominance. But societies are existing in such a way that there is a very strict control over this `natural' expression of all human beings. The following equation is upheld in all structures and institutions of society. Normal Sexuality = Heterosexuality = reproduction = male child (only in marriage)

Human beings are considered to be evolved beings who have a rich culture and civilisation with evolved communication methods. In such a situation identifying normalcy to such limited expression is in itself a problem. The story, however, does not end here.

It is only heterosexuality within marriage that has acceptance. Further a primary motive in establishing monogamy within the confines of the institution of marriage is to ensure paternity and patrilineality -- it is to ensure that woman bears the child of only a particular man. Naturally, then the emphasis is on reproduction and so heterosexual relations which would lead to conception alone are stressed. Finally again it is the male child who can supposedly carry on the lineage of the man and so bearing sons seems to be the only option.

Since women's fertility needs to be controlled, it is their sexuality which is controlled. They bear the child and so their body becomes a reproducer preferably of male progeny. This biological reality is translated in society to mean very different things for men and women. All responsibility for reproduction is on women. Men have none. Hence automatically contraception becomes women's responsibility. Sexual interaction for women is equal to responsibility; for men it is fun and pleasure. Simultaneously stereotypes of sexually inactive women and overactive, virile men are also constructed. This justifies and supports the practice of prostitution as an oldest profession. Men's virility is the excuse under which gross violation of women's bodies and persons is carried out.

Similar is the situation of rape or other kinds of sexual abuse. There is some unwritten sanction by society to men's lust and even assaults and acts of showing their power are waved off as a consequence of this lust. The range of these myths and their expression thus ranges from prostitution to rape to less number of vasectomies. All are related with notion of virility of men which is uncontrollable and is in many senses not evolved, `uncivilized'.

This equation sets the norms of behaviour in society. It gives a model along whose lines each individual tries to mould herself. The institutions in society are created to facilitate this process. naturally, reproductive health also gets defined only as women's health in their role as reproducers within marriage. All other aspects of women's lives are totally negated and so a large number of women who do not fall in this category of

`normal' woman and who may or may not be struggling to become normal.

This model prescribes the behaviour pattern for men and women. Men are supposed to be virile and aggressive. Women have to be most protective about their chastity and virginity. To preserve their body for that one man, they have to constantly behave in ways that would protect them from the naturally aggressive and lustful men. This is what creates stereotypes of female as well as male and makes us into the persons that we are. This constant fear of aggression has made women coy and shy, and fearful of their very existence. These abnormal stereotypes -- can they be called healthy? Shouldn't this also be part of reproductive health because it is related to the social construct of reproduction? At least while looking at a person's health we have to take into account these pressures that are operating on her/him.

In reality women are producers and reproducers. Their role as producers is no doubt affected by the overwhelming societal responsibility of being reproducers. The kind of training and jobs that women get and the opportunities that they can avail of while satisfying their societal role as reproducers, affects the rest of their life. So issues about occupational health should come under reproductive health.

Widows or deserted women do not have so called protection to their existence and so their reproductive health does not get catered to. If they have any problems it is considered to be certificate of their immoral activity and so they are forced to choose quacks and other treatments even if they are unsafe. These many women do not come under strict category. So we have to define reproductive health as concern of all women of all age groups.

Science, medicine health care system all have been aspects of this social construction, motivated and developed in the context of societal norms and values. These have been the agencies responsible for looking after reproductive health and so naturally they have accepted and adapted themselves to the above conditions of normalcy. Health itself is looked upon as ill-health or absence of ill-health. It is not looked upon in holistic perspective of socio-political economic and geographic existence of men and women even though technically this is the definition accepted by WHO. In case of reproductive health especially this is vital because whatever health care is prescribed is not to unhealthy persons but to supposedly health individuals especially in case of fertility control methods. The societal taboos do not allow women to talk about their problems of ill-health with respect to their reproductive tract especially the constant threat of STDs and now AIDS. This further has increased the silence in women to talk about their problems. This fear has made them more and more docile and also fearing type. In any case as far as women are concerned any problems related with their health are any way considered to be secondary,

less important. Only when it becomes impossible for them to carry on with their work, then only they talk about their problems, but it is not necessary then also that their problems will be taken seriously.

As we all know, the knowledge of medicine in most of the systems in the form of theory and at the level of practice has been kept away from women. Allopathy has aggressively curbed the existence of medicine women. We do not have sufficient studies about those practices in our society and no clear cut formulation on this issue but attempts of groups like Shodhini who have been working with medicine women in a few states in India are helping to trace in some sense all that is getting lost. The massive work done by this group is coming out soon in form of collection.

Scientists have always said that intervening in women's body to achieve control over fertility is much easier because of the cyclical nature of the menstrual cycle and hence of their fertility. Yet, whole aspect of menstrual cycle and its effects and affects on women and their body functions has been neglected by biology by considering only man's body as biological entity. World over, women are raising voice against it and separate research norms have come up in recent years.

Biology as a science developed in this society has the same biases and anti-women perspective.

The consideration of reproductive system being only associated with reproductive organs is good example of the overall attitude of science. The reductionists approach does not look at the process of reproduction as it being a function of the whole body. Babies are now being forcibly produced by menopausal women and even the comatose women. Brain is otherwise considered to be master of the body. But when it is question of reproductive system of women, the brain, one of the major actors in the process is not considered at all. The reproductive system is reduced to the so called reproductive organs.

One may find this a very simplistic, generalised and polemical argument but the role of other physiological and Bio-chemical changes related to the reproductive cycle which are happening every moment in the body is not researched beyond a limited interest. Irregular menstrual bleeding and its effect on women's life is not an important question for scientists. Whether it is experience as dysmenorrhoea during a regular menstrual cycle, are the effect of a contraceptive method or the experience during menopause.

Thus a general trend that seems to be followed is to negate existence of women and progressively reduce them to their ability to reproduce and identify their body with just their reproductive organs. At the same time reproduction and reproductive health are becoming issues of women's body, and within it of course of their reproductive organs alone. So the whole development and progress is towards achieving control over fertility.

We do not see much difference in the plight of women in urban and rural, developed and under developed countries. The availability of facilities to rural women are less and they do die because of the non availability of proper health personnel but then urban women have facilities at their door step but in monetary terms the facility remains at distance. The loss of control over their own bodies is brought about through control over their reproduction and it is true for all societies universally.

In all our minds, questions of contraception or controlling fertility and handling in fertility have become questions of technology -- of getting the right method. The social aspects are totally lost. But can any technology, however, efficient, harmless and good -- alone solve or attend to the issue which itself is based in society. Technology can just be an aid in handling a situation, it cannot ever provide the total solution.

We would like to share our experience in the sex determination campaign. We had initially asked for a punishment to be stated in the legislation for both the givers of the technology as well as the marital family of the women for the test. The state responded with a law in which the women were also punished. The central legislation also had the same clauses. Our experience at the state level, and also some amount thinking led us to take a very different stand. We said that this law is for regulation of technology. The doctors are responsible for providing it. Whatever be the demand of the persons who come to them, the doctors were in a position to refuse access to the technology. So our stand was that the punishment should be confined only to the providers of the technology.

The clarity came with a more clear realisation that neither technology nor legal reform alone can stop these practices of discrimination between boys and girls. This history of campaign has helped evolve an understanding today on contraceptives as well. We cannot just have a safe, efficient contraceptive method unless we are willing to talk about basic changes in the man-woman relationship itself.

These issues are more important today when technologies are today being developed to meet interests of certain sections. This is evident in case of assisted pregnancies and technology which is evolved and has national pride in such successes. When there are women who have been suffering due to ignorance, their subordination and their physical illnesses which is most important cause of their infertility are negated but attempts are to develop IVF as in case of India. Indian state is providing funds for both anti-fertility and pro-fertility research and its development. In developed countries it is more so because of the threat of extinction. In Japan during last 1 or 2 years, 150 In-Vitro-Fertilization clinics have been opened and with the nation's fear of getting extinct stated in these many words.

The biological ability to reproduce is tampered with as and when wanted according to the nature of the demand. These demands are

determined at International levels especially in case of anti-fertility technologies. We have felt in FFWH we should build up an opinion and campaign not against Norplant or anti-fertility vaccine but the basis of such contraceptives which are long acting and do not leave any control in hands of its user. In case of anti-fertility vaccine in particular there are larger issues involved. The basic contentions of it, many of you must be aware of. Mainly what it means to tamper with sensitive immunological system at a time when AIDS is rampant and the general pattern of diseases is changing rapidly and there are increasing outbursts of auto-immune conditions. Apart from that, the nation state boundaries which have been created in this century, are the rationale on the basis of which we have been campaigning for years together -- such as the use of contra-indicative drugs in third world without any regulation and warning given. But in this case of AFV, Indian scientists being the pioneer workers the question has to be addressed in different way. We have reacted and had very strong rationale of multinational industries profit motive and use by them of developing world's people as experimental animals in case of drugs especially. But now something is produced in India which is more harmful and is developed with its abuse potential being stated as its virtue, as one of the positive aspect of the anti-fertility vaccine. In this campaign we felt it is important to see the development of such harmful contraceptives in the larger context of development and population politics of control. The need of women to control their fertility has been exploited by the politics of population control policies outright.

Science has been proved to be rational and has appeal of universalisation, generalisation. Science has that appeal over traditional systems which are specific and localised. But progressively science has lost its appeal to have value free, rationalist approach. Today science is involved in providing contraceptives which supposed to be giving a wider choice to women to choose in their malnourished, anaemic conditions to save them from maternal mortalities and abortion related complications. Here we are not going into numbers and we do not want to base our argument in statistical method but we want to stress against one point that women want contraceptives because they do know the difficulties in their lives at all levels. They want to use contraceptives as a rebel and want to use contraceptives without knowledge of their husbands and in-laws who are not bothered for their lives anyway.

This need for contraception is met in society mainly by the health care system. In India, this task has been carried out by the Family Welfare Department initially called Family Planning Department. This history of the FP programme in India most of us are aware of. A programme that began as a birth control programme and had education and awareness raising as its main support has today become a family welfare programme with greater emphasis on using all available technology to achieve population control and hence reduce population growth. It has supposedly taken care of women's health because once again it is just this

reproducing ability which is to be given any special attention so the only progress we had was MCH. This too has been now taken over by the FP programme. The Family Welfare programme has constantly rising budget and even in times when there is reduction in overall primary health care and preventive health services, this programme into which more and more money is being put.

Recent developments in the programme are even more disturbing. There are efforts at involving NGOs at all levels to ensure implementation of the programme. Within the programme itself while on the one hand there is stress on long acting, provider controlled methods, on the other hand there is a greater emphasis on women's development and empowerment. This to us appears to be a two pronged attack on women's autonomy and independence vis-a-vis their reproductive health.

One is the consistent, physical, invasive attack of technology and the other is taking over by the state all the terminology and concepts with which women have begun to unite and redefine themselves. Women's empowerment, development and organization is all being geared to one goal, that of achieving population control without changing the basic parameters and definitions of reproduction or womanhood or manhood for that matter. Without allowing a new approach to reproductive health, it now appears that other areas of her life be it literacy, employment or other such aspects all are just being reduced to reproduction.

Finally to be able to look at reproductive health differently, it is divisions between women and men, between laypersons and experts, between women and women, between persons and their bodies, between individuals and society that we want to minimise because in reproduction and in determining reproductive health each of these contribute and because each one of us reflects many of these apparently contradictory categories simultaneously.

SOME THOUGHTS ON CLINICAL TRIALS

The Phase III trials for Norplant-6 are currently on in ten Human Reproduction Research Centers of Indian Council For Medical Research all over the country. Peculiarly this contraceptive is being offered to women along with already tested ones like oral pills and Intra Uterine Devices in the Family Planning Programmme in a cafeteria approach. This decision as well as the design of these trials have raised many medical, social and ethical issues.

In this exercise, we in the FFWH would like to focus on the research methodologies involved in these trials and very basis of the so called scientificity, objectivity as well as who decides what for whom.

The Question of Ethics

The issue that has been raised most often has been of ethics and within that too, that of informed consent although agreed upon paper, in reality nothing is informed to the woman undergoing the trial. The question of telling the good and bad effects of the particular contraceptive being tried is redundant for even the fact that it is a trial in which something with unknown effects is being tested on `normal' women is not revealed.

Right from the experience of the NET-EN trials to the testimonies of women on whom NORPLANT and vaccines are being tried, this has been a common observation recorded by various people. This total lapse in maintaining basic norms of ethics has been explained away as an objective, scientific way of carrying out scientific trials.

At the same time claims of scientific trials are many a times for trials are many times moulded to suit the requirements of many agencies in whose interests the long-acting, provider -- controlled contraceptive or any drug/contraceptive work.

Animal Trials are considered to be the basis on which human trials of drugs are based. The results of these are, however, very much interpreted according to the needs of the researcher and the establishment. When Depo-Provera proves to be carcinogenic to beagle dogs exposed to it, we women are told that we need not worry about the similar problems because we are so different from the dogs in any case.

At the same time and in the same vein, human trials of anti-fertility vaccines have begun because of its positive results when tried on animals. In this case, the fact that the supposed antigen molecule is a foreign element for the animal but it is something naturally produced in women's body and is hence not foreign also does not stop the similarity from being drawn.

The point is that once it is decided by the providers that long-acting contraceptive of particular kind are needed and are safe, this is what is proven apparently very `scientifically'! The latest example has been again of Norplant.

The problem began from last year when Government decided to carry out phase IV trials for Norplant-6 without having carried out the phase III trials for the same. The `scientific' argument that was forwarded was that since phase III trials had been done for Norplant-2 and Norplant-6 contain the same synthetic hormone, namely `progestin', the phase IV trials of Norplant-6 could be started straight away. The truth, however, was that though the basic hormone was same in both, the implants were made differently. Norplant-2 had two rods of a silastic material that were impregnated with hormone and Norplant-6 has six capsules made of a different silastic material in which the hormone is filled. The silastic material used for Norplant-2 was found to be carcinogenic to the workers working in its production plant. Hence further animal studies were demanded and to evade the `costs' to carry such investigations the manufacturing of Norplant-2 had been halted.

The plea for carrying out phase IV trials directly was that both these implants released the same chemical in the same quantity into the blood stream. That their method of delivery was different, that the material of which they were made was different was then considered inconsequential. In the face of a strong protest from all over the country, this move was altered and phase-III trials of Norplant-6 were announced.

The process of fooling under the garb of scientificity has however, not stopped even now. Now phase III trials of Norplant meant testing the efficiency and effect of the drug or device are proposed to be carried out along with testing of acceptability which is a criteria usually tested in Phase IV of the trials. For this, a so-called cafeteria approach is being propagated. So the study tests women's perspective on spacing methods are offering them the pill, IUD and Norplant simultaneously and asking them to make the `choice'. How can an untested contraceptive method be offered along with others which have been used so openly and rampantly for so many years and hence which have been tested in the Indian context? What is the ethics of such trial? And what is its `so-called' objective scientificity.

The objective scientific paradigm

This brings us to very crucial aspect of clinical trials, which is, the objective scientificity. Although all the above examples are from Indian context, it is not as if this is an issue of misuse or misrepresentation of `scientific method' in a particular social situation. The scientific method itself has space for the researcher's subjectivity.

It is not the subjectivity that we would like to question. The objections are to the fact that the process claims objectivity and hence makes the result appear to be objective and value-free. As a result it successfully hides the existence of any agenda in the process of scientific enquiry. It projects it to be something that is open neutral quest for knowledge while in

reality it is far removed from this. The research on contraceptives has revealed this reality.

In fact in the clinical trials the objectivity is demanded of the person who participates in the human trials. But precisely for this reason, information on trial and trial product is not given to the subject. The `scientific' reason given by the researchers is that if they tell women about the possible side effects, they would turn hypochondriac and start `imagining' all those `side-effects'. This would prevent any `objective' evaluation of these side-effects.

In the absence of the knowledge about how a particular contraceptive works and in the situation when contraception is a dire necessity, many a times a lot of side-effects are not connected to the contraceptive and hence are not reported. Not knowing anything about hormones it is difficult to imagine that something put under the skin of the forearm could lead to pain in the calves!

At the same time, the openness required of the researchers also does not exists. He/she has a set of given symptoms to look for naturally ignores many others that might be connected. There is an understanding about how contraceptive works and only those aspects that fit in to this understanding are looked into. All others are ignored. Unless there is an openness towards the fact that the basic understanding itself is not necessarily complete, the trials themselves could miss out on a number of crucial side effects and problems.

The problem is hence that an objective method essentially just succeeds in negating a lot of subjective experiences. It is not possible to eliminate subjectivity. The issue is of recognizing this subjectivity and stating the vantage point from which observations and deductions are made.

Reductionist approach

Not accepting the role of the subjectivity of the researcher has a deep connection with the arrogance of possessing an understanding. At any point in `scientific' research, it is necessary to acknowledge the transience of the understanding. In modern science today, it is the reductionist approach that prevails. Looking at the whole as a conglomeration of its constituent parts is the method applied to all matter - living and non - living.

The body then is looked at as made up of its organs and in the process the active interdependence of various organs is negated. With this approach, it is almost impossible to look at the body as a whole and hence effects of the contraceptive being are also not seen on the whole body but are restricted to the particular organs on which contraceptive is supposed to work.

The side effects recorded and noted or observations made in the case of contraceptives, all essentially deal mainly with the reproductive organs. For example, with Norplant it is assumed that it affects the hormonal cycle related to reproduction and so only those effects are studied. In fact, Norplant disrupts a natural body cycle continuously for five years and yet removal is the only thing that is checked, is whether the woman can conceive again or not (the Norplant is a contraceptive and affects conception) with the unidimensional attitude that return to normalcy after removal of Norplant is confined to observing whether there is return of fertility or not. Since assumption is that other systems are not affected, it is not even felt important to see if there are any other long-term effects on the rest of the body.

Even while studying the effect on reproductive organs, the observations are confined to the woman's organ alone. It is quite possible that although there is conception, there could be some disturbances in the reproductive system which would affect the progeny and their reproductive capacities. Follow up with at least one generation of women exposed to systematic changes for such long periods is the minimum that could be expected of a research trial.

These, however, do not ever become the concerns of the `scientific' researchers. The belief in a reductionist paradigm has led to a lot of problems of short-sightedness in various areas of science and technology. In contraceptive research the urgency is of controlling population by more effective ways. Cost of women's health is probably a small cost in the process. Yet, there could be unpredicted, irreversible effects which would alter the picture of the population. The effects of drugs like DES given to pregnant women are still visible in the disabled, cancer prone, infertile DES daughters today. These are lessons of this century which have to teach us to pay heed and get over our sense of urgency leading to destructive short-sightedness.

The pace at which new technology is being introduced, however, does not at all take into account such questions and concerns. Newer contraceptive methods are evolved to control reproduction since that is the major goal identified today and hence is pursued at any cost. The cost-benefit analysis which serves as the basis for acceptance of any technology is done without questioning the basic definitions and understanding of costs to be paid and benefits to be achieved. In this process the justification is further obtained through the most `effective' tool of modern science, that of statistics.

Game of numbers

Something is statistically significant or not seems to be just a number evolved through rigorous mathematics. Yet what is hidden behind this index or co-efficient is a base and background of subjective social values. Objectivity demands negation of personal experiences and generalization based on the statistical

data collected. If the person's body undergoes drastic changes many times it does not matter so long as the average is within the decided norms or the changed status of the body is normal according to the averages calculated gain Norplant-2 phase III trial results are important to study. Reportedly by the end of two years (which is when the report was written) 17% women had got their Norplant removed due to complaints of menstrual disturbances. These were the women for whom the pain and trouble was unbearable. For whom fulfillment of even the dire need for contraceptives could not be compensative enough for the pain and discomfort.

Other than these extreme cases, the menstrual disturbances caused by Norplant is studied in terms of certain average numbers. A three monthly observation of each woman was done. If that woman menstruated two to four times in these three months, had cycles of 22-35 day duration, bled for 10-20 days and maybe had some spotting for a total of about 10 days in that period, it was assumed that she did not suffer from menstrual disturbance.

The criteria seem very exhaustive and considerate until one looks carefully at the experience of an individual woman that is hidden in these neat, specific numbers. A woman who has a regular cycle of 30 days and bleeds about 5 days during each menstrual period is considered to be `normal' by these criteria. If with the Norplant her period changes in such a way that she has her period after 35 days and if she bleeds about 10 days each time and maybe even spotting for few days (something she never had before), she would still be normal and `scientific' decision would be that Norplant does not affect her menstrual cycle or that she does not suffer from menstrual disturbances due to Norplant!

Another game of numbers is played when deciding on the sample size for the phase III trials for testing of contraceptives it is necessary in this phase that observations be made for twenty thousand menstrual cycles. This could be achieved by studying two thousand women for ten menstrual cycles or two hundred women for hundred menstrual cycle or whatever be the combination. This appears to be large number until one realises that the criteria has remained the same for all contraceptives including those that are supposed to work continuously for five years. In case of

Norplant -- a contraceptive for sixty months this would have meant a study with about four hundred women for five years.

Here the number is much smaller but we presume that the study is done for full period for which it is supposed to be used. In actuality, however, one thousand four hundred and sixty six were involved and a total of twenty thousand six hundred and sixty nine menstrual cycles were studied. This meant that the results were based on trials in which women were observed for only a period of one year or two years.

It is quite obvious that for testing of long-acting contraceptives, studying 20,000 menstrual cycles is not at all sufficient. It in fact presumes that there would be no special effects on the body in spite of the long-term, continuous exposure to that contraceptive. Flaunting scientifically while actually fooling us with the results that arise out of each lop-sided trials is hardly something that can and should go unchecked. And here comes the most crucial question.

Calculation of Costs and Benefits

Once we accept that no research or process of generation of knowledge is value free; once we acknowledge that even the most objective looking processes are colored and affected by the subjectivity of the person/agency generating it; once we recognise the role of social norms in determining what are facts - we can not talk of costs or benefits without answering the more basic questions of qualifying what one means by costs and benefits. Benefits for whom at whose costs has to be clearly spelt out before even making the facts known.

As far as the long acting contraceptives are concerned, the fact that they act for a long period of time itself means that they do not leave any space for intervention by the person on whom they are used. They mean a total dependence on that particular drug or device and hence on the agency that is responsible for providing that particular contraceptive. In that sense they are mainly and specifically developed for purposes of eugenic population control. They are aimed at and used against the most deprived sections of the world's population and meant to control these populations.

We believe that so long as the agenda remains the control over population there can be no benefits for women on whom all these methods are used, it is pure and simple control over their bodies to gain other ends. All research and development in this area will be affected by this attitude and aim and hence it needs to be questioned at its very basic tenets.

Women are made the targets of all reproductive technology apparently because their bodies obey certain cyclical pattern. Hence the scientists claim that it is simple to intervene in their bodies. They also produce only egg at a specific point in the cycle which again makes it easier for an external agent to exercise control. Then again because women's bodies finally carry the child and produce it, it is assumed that they are more responsible for the process of reproduction.

In all this very scientific reasoning there is, however, a strong reminder of society's norms and biases which are shaping the direction of research. Reproduction is more and more becoming women's business and controlling it is society's. So the vaccine against sperms is said to work best also in the women's body! At the same time as more knowledge about human bodies is produced, we are getting lesser access to simple facts about our biology.

So in spite of the claims of the scientists, we feel that this attitude is arising out of what society believes in, rather than out of the specific biology of women.

The Way Ahead

Within this scenario the question before us surely is of how do we move ahead. If we have to stop reacting in a piece-meal fashion to every new method that is being introduced, we have to define ourselves and our needs better. We have to define for ourselves what are our expectations from any reproductive technology. While critically examining the research processes and methods it is essential that we begin to take control.

On doing some thinking along these lines we have felt that the process of reproduction and conception has to be relocated in the interaction between the man and the woman. Obviously then any control over it would be achieved by alteration in this process. Making internal changes in the body so that the egg or the sperm are not produced would be methods that would begin itself at the wrong point. According to us chemical interventions in normal human beings is not something which denotes any kind of control. When we looked at this way `minor' side effects actually appear to be serious conditions as they are result of an unnecessary intervention.

When one begins from this point, the evaluation of the reproductive technologies has many different dimensions. It requires that the research processes also altered. There is no need, to fool ourselves with lop sided analysis and results. The direction of research, the methods used, the norms of ethics followed will all have to be very different. They have to be more `person' oriented; more for the user than for the population controller.

NORPLANT

REFLECTIONS ON SOME EXPERIENCE

These are first person accounts of women who have undergone Norplant trials in Baroda.

All the women whom we met were unaware that they were participating in trials. They were told that it was a new method which would give a contraceptive effect for five years, that they did not have to worry for five years about getting pregnant, and that they would not have any problems with the new method.

All the women wanted a safe and good contraceptive. It was their dire need and they were aware that all other existing methods had some problem or the other. This was a new method and the problems associated with it were unknown to them. That was the reason they opted for this new method.

No one had taken any pains to tell these women anything about Norplant. It was considered sufficient for women to know that these rods would stay in their arm for five years and would take care of their need for contraception. When we met the same women we did not feel at anytime that they were uninterested in knowing more about it. They showed tremendous curiosity to know more about Norplant. Our conversations with them were a process of sharing of information about Norplant and learning from their life experience with it and was very educative for us. It was also felt that we should be carrying out similar work more systematically and with a larger number of women. It is an essential and necessary task that we hope all of us will be able to take up together.

We felt that the trials were unethically conducted because firstly, no information was given to the participating women about Norplant. The women were even unaware of the fact that it was a trial. All the basic WHO guidelines about informed consent and other related matters turn out to be absolutely meaningless in this respect. Follow up of patients was also conducted as casually. When Dr. Badri Saxena was questioned about this he told us that keeping track of any person was an impossible task. Some of the women said that they went regularly to the hospital. Some said that the social worker from the hospital used to visit them. Almost everyone said that they got a letter whenever they missed a visit. But in the follow up visits in the hospital nothing used to happen, no investigations were performed. So, if they did not have did not think they had any problems they also used to skip hospital visits.

Here we would also like to add our experience at another ICMR, HRR centre at Thane. Here seven Norplant trial participants were simply missing and of these two were totally untraceable! We feel that this also shows the kind of women who were chosen for the trials. Women who had no permanent address probably lacked housing , lacked work and were vulnerable because of their circumstances to pressure to enroll for the trials.

In Baroda also, the selection of women was carried out in a very peculiar manner. The Sayajirao Gaikwad Hospital where this unit is attached had asked the Baroda Citizens Council (BCC), an organisation working in the slum areas on the health and other issues. The auxiliary nurse-cum-midwives (ANMs) of the BCC were given the job of bringing the women for the trials. The ANMs were unaware of the Norplant trials and their information was on par with that of the women participants. Women with at least one child were chosen, probably because women with proven fertility were to be selected. Those who had two, three or more children were preferred. This may be because exposure to Norplant and risks of infertility would not make much difference to such women. They might also have been chosen because they did not want to be sterilized immediately.

One more fact about the Baroda trials was that many women who underwent trials were Muslims and from Uttar Pradesh. To keep this target population the slums were chosen also with predominant population of Muslims and people from U.P., basically minorities, religious as well as regional. There is a belief about both these communities that they are reluctant to use any contraceptive methods. So it would look as if there is a hidden purpose of the government to thrust this five-year contraceptive onto this population through the family planning programme. This method takes away the control of women over their fertility without their realizing it, without any active participation from them, and can also achieve this without it being revealed to any family member.

What tests were actually carried out on the participants in the Norplant trials it was not possible to get. It was clear from the kind of answers given by the women that it had not been done systematically. Only one thing is clear that urine was checked in order to make sure that they were not pregnant. Each and everyone of them had undergone PV examination. None of them were sure about the blood test. History was taken about illnesses in the past. Whether they were suffering from any major or contraindicated illness was not checked. Most of this information was orally asked. Blood pressure was checked and the date of the LMP was recorded. We also met one woman who had delivered and was still breast feeding the child and her menstrual bleeding had not yet restarted. Actually, it is known that breast feeding women should not use Norplant. Three of the Baroda women kept on breast feeding even after Norplant insertion. They were told specifically not to breast feed but they had received no explanation of why they should not do it, the reason behind it. When one of them had specifically asked the doctors about breast feeding, she was told that it did not matter. Once again it shows that women were not given full information and left to face by themselves the unknown consequences of the drug. What will happen to the infants? What would be the effects of the constant hormone level in the mother's blood? Who would take cognizance of the unknown consequences?

No woman complained about any problems encountered during insertion or removal. Everyone experienced it as a simple procedure. All of them had different experience of Norplant after insertion. Two women out of the nine had to have it taken out. Another one had a problem but kept it for 2.5 years. Another did have problems but did not need a contraceptive since her husband had gone away for a job. Leela became pregnant in 1.5 years and so had to undergo abortion and face removal of Norplant. Of the remaining four women two had problems but they could not relate it to Norplant and one of them does not know whether there is a link or not. One of them had problems of menstrual irregularity before Norplant insertion but fortunately it has not added any further complication. We met only one woman, who could be called a classical case who had absolutely no problems. She was very vocal and a confident looking woman even otherwise and we felt during the conversation that she seemed to be enjoying a victory, in contrast with the women for whom Norplant had failed.

It also gave us some assurance that once a woman has control over her reproduction, she acquires a different kind of self confidence. As the pill did in the west, she acquires a kind of self determination. Perhaps this interlinking on our part is not quite correct because we don't have cause effect analysis. Control over reproduction means many other things, for example, change in their relationship with their husbands, getting rid of the constant fear of getting pregnant -- all these things come along with control over reproduction and it was not possible to know much more about these aspects in the half-hour that we had. One thing that stood out sharply was the attitude of her family members and her situation in that respect and her suffering.

We have to understand all these complexities in connection with these trials which are based on scientific methodology and in the `objectivity' of science. In such complex situations it is not possible to be objective and we feel that the researchers should state openly their subjectivity. What is their aim in these trials? What are they trying to find out about Norplant? What is their own opinion about Norplant? All this they should state explicitly otherwise it becomes impossible to get a clear, total design of the trials.

What we found through the experiences of our interaction with these women is that the experience of using Norplant had a definite role to play in their lives. What other contraceptives had they used? What was their condition like when Norplant was inserted? These and other such things determine their experiences. It is dependent on all the above complexity in their lives. Whenever we asked about Norplant the initial response was that they did not have any problems. Only those who had severe problems answered differently. Probing a little more we always found many problems but they were not thought so because they were `bearable'. Or because it is accepted that in any case anything you may take there are problems, and they have to be suffered. So, even whether there is a problem, and its

extent are determined individually for each woman. It is decided on the basis of one's conditions.

Whatever we gathered during our conversations was also based on the participating women's subjectivity. Our subjectivity determines what we shall find important. In such experiments, objectivity reduces itself to numbers: 1) number of participating women, 2) number of women who kept the Norplant throughout the trial period, and 3) number of women who dropped out of the trial either because of failure or any other reason not related with the experiment as such. So essentially the only objectivity is in the figures of continuation, discontinuation and failures. Why these many continue or do not do so are all reasons which have no objective answers and cannot say that Norplant is acceptable because it is good.

This can be said about our observations also. But there is one difference which needs to be stated. During the trials there was no clarity of perspective. Along with this lack of clarity there exists a package which frightens us. This is linked with holding on to the information which needs to be disseminated: information as to what is Norplant, what effects Norplant has, what effects it can have on the body, what are the caution signals, etc. Without telling women about all this but just collecting information about their experience is nothing but plain and simple injustice to women. It indicates not only the observer's subjectivity but also a false process in the name of the retaining the objectivity of the one who is being experimented upon.

Along with all this, is the advantage taken of women's situation. The faith they have in the doctors is also similarly used. With the lopsided model of research they are playing with lives of woman. To retain the objectivity of the model, women are reduced to an object. That is why it is not only a researcher's subjectivity. It goes beyond that and creates problem of different kind.

In getting deep into their research and with the power of their knowledge, researchers become blind and it is reflected in their narrow perspective. Norplant is one contraceptive and its contraceptive effect is for five years. So the study is done to confirm this effectivity. Then all the hormones related with menstrual negative feedback were checked. This checking was done to the extent of, asking about menstruation etc. After taking it out, the wound was observed. Regaining of fertility was checked and all testing was over. For five years a chemical is released daily into the body. So menstrual cycle and other cycles get disturbed. What is done about it? After removal of Norplant no examination takes place to link it with other problems in the body. Perhaps the probability of determining cause and effect of Norplant is a difficult task after removal of Norplant. But isn't it necessary to continue the observations? We really wonder where this reductionist approach is going to take us.

At least three of the women whom we met had problems. These problems could have been due to hormonal equivalent getting absorbed in the body for such long time and disrupting a monthly cycle for five years. For the two women who had undergone weight loss, it is more or less permanent after removal of Norplant. To get back their health to previous level seems to be improbable. They are getting treatment to overcome the weakness. But the doctors who are treating them have not been told about Norplant insertion. Again ignorance and blind faith in doctors ability to help them out, cure them and to get rid of weakness. These doctors will load them with medicines without any effect. Their bodies are again becoming playgrounds.

Before these conversations, whenever we had tried to talk with doctors, all the time the point about the effects of long-acting contraceptives used to be sidestepped by them completely. They used to insist on a single point -- of return of fertility. That means effect on the body is limited to contraceptive effect. This definitely creates doubts in mind about the similarity in approach of the doctors and the most ignorant women. Both take decisions based on obvious facts. For doctors Norplant is definitely a contraceptive so they restrict themselves to information related to that aspect only. The women's knowledge about their bodies is so limited that the Norplant in their forearm appeals more to them than the Copper-T which is invisible and placed in the uterus.

This perspective of women we got through this discussions only. According to Madina, the Copper-T is put inside her body which is a dark area for her and she does not have direct contact with that area. Then many women have experienced displacement of Copper-T. When it is not seen by eye one feels doubtful about its action. Norplant is there in the arm, if it begins to be displaced there will be immediate knowledge about it. Something inserted with minor surgery without feeling ashamed about it is better and does not seem to violate one's body as something that has to be inserted through the vagina.

That is why Norplant becomes a choice. It is accepted with all its pluses and minuses. By showing faith in Doctors, taking balanced view of one's conditions, with half-knowledge about one's body and with a strong belief that they won't become pregnant, along with pressure of social sanctions makes women opt for Norplant. Doctors are supposed to be helping them out by bringing out more and more such contraceptives. But really what help are they offering and to whom? Women have to bear with all the problems because the method is giving them relief for five years. The only plus point seems to be its contraceptive use. For that they have to lose control over their body and hand it over into the hands of doctors through these six rods. And all this is to achieve birth control for five years and allow oneself to be free of responsibility of one more child.

In fact, the way the women undergoing the trial are chosen and treated, the whole process seems to be an ultimate violation of the concept of women's choice itself, through the exploitation by the donor agencies or the contraceptive providers. And all this is, ironically, done in the name of providing women what they need --a `good' birth control method !

In this conversation some women said "if they would have told us all this we would not have gone ahead to insert it". Whither informed consent and where women's choice? Incidentally, all these women completed the trial successfully. After taking our Norplant, Madina had a rash on her face, and she took medicine for three and half years ! Of course she did not really connect it with Norplant and in the absence of anything which can prove such kind of connections, we are at a loss.

These conversation were very educative at personal level. When we had gone to interview the women we did not had any idea about the outcome of these interviews. But now we feel at two or three levels this process had helped us. First is to know about women and in what conditions they have had Norplant inserted and their experiences of Norplant is very important and necessary, to substantiate our own conjectures. The way in which women perceive pain and problems; their need and compulsion to accept such methods; their experience with the doctor and health care system -- all were very vital in enhancing our understanding.

Secondly, what these women have undergone is in total ignorance. Now onwards whatever is happening to their bodies, the experiments done on them make them alert or cautious and to insist on knowing how the contraceptive works. This can be our collective effort.

Here are a few interviews with women from Baroda (Leela, Gouri, Meenaben, Sakina, Madina)

Leela is 34 years old. She has three children. Two daughters and one son.

"There is a six years" gap between my two daughters. My husband was staying in the city during that time. When he returned to the village I used Copper-T. But it did not suit me and I had to suffer a lot. Finally I had to get it removed. I became pregnant. What could I do? After delivery I went to hospital again, the lady doctor told me a few things. I wanted some contraceptive method but I had doubts in my mind. I was scared to use pills. I had heard that to do heavy work while on pills is not possible. I earn by doing tailoring jobs. I had already experienced of Copper-T. This time lady Doctor told me about the new method. She explained to me that there is minor operation in which something like rod is fixed under the skin on the arms. And it will do its job of contraception for five years. The name of the method is Norplant. I was scared about the difficulties involved in this method. But the lady doctor assured me that

there are no problems. I did not had any other choice as well. So I got Norplant fixed.

After implanting Norplant I used to go every month for checking. Nearly after one year I missed my periods. Ten-fifteen days after my monthly period gone and I started getting worried that I was pregnant again. I went to the doctor again. Nobody willing to accept that I was pregnant. After a lot of trouble and pleading my urine was examined. I was pregnant. I was advised to go for abortion. I was helpless. Not only that the doctors aborted me, but took away Norplant as well. Once again I had to get Copper-T fixed. My troubles started again. I felt defeated and removed the Copper-T. Now what is to be done? I felt disgusted with my body and its adamance. I have heard that periods stops? Can you tell me, when will that be for me?"

The story of Leela is not uncommon. Leela was not told that Norplant is a new method and it is implemented for trial, and so doctors also do not have full information about Norplant. She had weakness and was suffering from anxiety, but doctors did not bother to take that into account. Not only that, she was told to relax for five years.

None of them tried to tell her, explain to her that it is failure of the method. It is not failure of her body. It is not her fault to find some method unsuitable. But deep down she believed that it was all the fault of her body.

The fact is that any contraceptive method can fail. But it is fault of only of that method which takes over the body and disturbs the natural functioning of the body.

Gouri is 26 years old. She had a son before implanting Norplant. She says, My first child was born unknowingly. I had not used any contraceptive method. After that one of the ANMs coming to Basti told me about a contraceptive method which can be used for five years. I was very happy to know about this method which will take away my worry for full five years. I went twice to the hospital and got Norplant inserted. I was very happy then. I continued breast feeding my son. I was totally in the dark about future and what was there in store for me.

"I do not know what exactly happened to my body after the insertion of Norplant. Every eight days there used to be bleeding like my periods. The bleeding used to go on for five days. My whole body used to ache and I used to feel very restless. Almost half the month I used to bleed. I used to feel bad about sitting away in the house for half the month. My husband also was unhappy with me. We had to sleep separately for half the month because of the bleeding like in monthly period. We could not have any physical relationship, he started abusing me a lot. He even threatened to leave me. He used to say, `what is the use of having a wife, whom one could not touch whenever one felt like?' He started abusing me outright as days passed."

"I wanted to take out Norplant. I made several visits to hospital, to request the doctors to remove the Norplant. Everytime the doctor used to find some excuse to avoid it. Earlier they used to say, that these trouble will be there only in the beginning. Later it would be all right. Then they gave me some medicines to stop my trouble. They also assured me that everything will be fine after few days. After that my trouble did not stop. I kept on going and sometimes the doctors used to tell me that they do not have any time. It was only after number of visits to hospitals had been fruitless that I went to big hospital. I threatened them, then only they removed Norplant."

This was not the end of Gouri's painful and troubled story. She became pregnant within three months of the removal of Norplant. During all the nine months she had bleeding. She also had body ache and pain in the abdomen throughout her pregnancy. She delivered an underweight baby, a daughter with one eye small from birth.

She was not knowing that she is part of an experiment. It is said that all is done by doctors is for your own good, but then nobody had bothered to tell Gouri that she should stop breast feeding her child after insertion of Norplant.

Irregularity in monthly cycle causes weakness and trouble for women. At the same time women have to suffer from psychological tensions. Doctors can ignore these, saying these are only in the initial stages. However, in order to find relief from these pains and troubles women like Gouri have to make several trips to the hospitals and plead with the doctors. When there is so much harassment to remove Norplant at the experimental stages, any woman can imagine what all the poor women will have to suffer when a Norplant work Rs.1000/- will be implanted in their bodies. Will the women control their own bodies or some external force -- be it doctors or governmental policy? is there any way out to find out whether Norplant is responsible for the problems of Gouri's daughter's troubles as well.

Meenaben is 28 years old. She had one daughter and one son before fixing Norplant. She runs a shop along with her husband.

Her elder brother-in-law works in a hospital ad on his advice she got the Norplant implanted. She says,

"Earlier we were not using anything. I became pregnant the third time when our second child was three years old. I went to the hospital for abortion because we did not want a child just then. I wanted to go for Copper-T. When I heard about this new method. I felt there would not be any problem after fitting Norplant and I would not have to think about anything for five years. But my whole life changed after Norplant. I used to be worried that my periods go on for eight days. I used to feel very weak. On top of it I had to listen to everything that my mother-in-law used to say. I had to sit separately during my periods. I could not participate in any festivals. I did not have the energy to do

anything. I used to cry at my condition. Once I had a fight with my elder sister-in-law because I could not share in the daily household work. I could not look after my children properly.

"So I did not even feel like eating anything. What can I say? My whole life was terribly disturbed. I had to bear everything, since the elder brother-in-law had advised me to get Norplant fitted and he was working in the same hospital.

"Finally, I felt defeated and took the decision to have Norplant removed after two and a half years. It was not so simple. After a lot of reluctance and avoiding me for nearly six months, the doctors finally removed it. During this time my weight had reduced by seven kgs. After removing Norplant my periods have been regular. I am still taking treatment for weakness. Even now I do not feel physically fit."

Meenaben also did not know that she was participating in a trial. She had used a technique which was still not tested. She is still taking treatment for her weakness but neither she nor the doctors know how far it is linked to Norplant. Meena did not even know how far it is linked to Norplant. Meena did not even know that for the treatment of any major illness it is necessary to tell that she had got Norplant implanted earlier.

If Meena had known that whatever she had been told before implanting Norplant was not only half truth but even false, she might have been saved from the weakness, physical pain, psychological tension which results due to the irregularity of monthly cycle.

Sakina is 27 years old. She already had one daughter and one son before implanting Norplant.

Sakina got married at a very young age. Both her children were born in a short-while. She also wanted a contraceptive like all of us. Sakina's neighbour's name was Salma. Sakina's husband's name was the same as Sakina's. Sakina had volunteered herself for Norplant. But her family members refused. So Sakina got the Norplant using her neighbour's name.

One major condition of Norplant was that any woman wanting to fix Norplant should not have a child below the age limit of six months. That is to say the child should be above six months. Sakina's child was only four months old. But she got Norplant implanted because she needed it.

She also suffered a lot because of this technique. Her periods became so irregular that she used to think it would start literally anytime. Before the periods there was a problem of white discharge. Doctors gave tablets and also advice (which was available freely). Sakina had to suffer because doctors were not at all willing to remove Norplant. In four years she became so

weak that she was in no condition to bear the baby. Finally she felt defeated, got herself operated to remove Norplant.

Actually Sakina wanted a contraceptive method which would prolong the gap between her two children. She only wanted control over her fertility not to lose it. But who cares about need? If she had used any other method she might not have become so weak. Nor would she have to undergo an operation. We don't know how many women there are like Sakina who do not want to have a child only for a particular period. For this it is not necessary to use such a long term measure as Norplant. We don't want such methods which so ruthlessly play with our body and completely distort their natural processes. Also one is scared to think what further troubles there will be and what will be the evil effects on the children born after this.

Madina is 25 years old. She had one son and one daughter before implanting Norplant. She said --

"Our neighbour Salma had adopted the same method. I had two children. I didn't want any more children, so I went and got Norplant implanted. In the beginning there was some problem. I was very happy. But one day there was a letter from the hospital that many women have suffered from Norplant so it will have to be removed. Although I wasn't willing Norplant was removed."

Madina doesn't remember any problems. Neither family planning officials nor her family members were concerned either about her need or her liking. She had experienced swelling of her body and there was rash on her face nearly one month after the removal of Norplant. She took treatment for the same for three and half years. Is there any correlation between these problems and Norplant? Who can say, any of the doctors or scientists?

It is essential to remember that other body functions may get affected because of Norplant. She might not have told the doctors that she had sometime implanted Norplant. it is also essential for every woman who is going to get Norplant implanted to know beforehand that the troubles associated with Norplant may be there during Norplant and may also continue even after the removal of Norplant.

The next question is that of willingness/choice. Does Norplant consider your convenience and desire? Don't be under any illusion over this aspect. What a woman wants has never been the consideration of those developing this contraceptive method. The experience of all these women clearly shows that whether you suffer or don't suffer due to Norplant, you are entirely dependent on the doctor to remove it once it is implanted. if the doctor is not willing, there is no other way of removing it.

It has to be remembered that it is an experiment. Once the Norplant is implanted the body itself becomes a laboratory. Nobody can say what its possible side effect can be on either the

woman or on the child born later. you, yourself will have to take a decision. What you need is an effective contraceptive method which is free from these effects. Do not compromise on it. Do not let your need turn into helplessness.

-FORUM FOR WOMEN'S HEALTH (FASDSP)
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CALL FOR A HALT TO RESEARCH ON ANTIFERTILITY `VACCINES' (immunological contraceptives)

We, the undersigned, call for an immediate halt to the development of immunological contraceptives because of concerns about health risks, potential for abuse, unethical research, and the assumptions underlying this direction of contraceptive research.

Groups of contraceptive researchers worldwide have been developing a completely new class of contraceptives for the past two decades. Immunological contraceptives, also known as antifertility `vaccines', are being developed primarily for women in LACAAP * countries.

Five major institutions are currently carrying out the research:

> The National Institute of Immunology, New Delhi, India;

> The World Health Organization, Geneva, Switzerland;

> The Population Council, New York, USA;

> The Contraceptive Research and Development Programme (CONRAD), Norfolk, USA; and

> The National Institute for Child Health and Development (NICHD), Bethesda, USA

A variety of organizations are funding this research. They include the World Bank, the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP), the Rockefeller Foundation, the US Agency for International Development (USAID), the International Research and Development Center (IDRC, Canada), and the governments of India, Norway, Sweden, United Kingdom and Germany.

The stated aim of those developing antifertility `vaccines' is to induce temporary infertility by turning the immune system against body components which are essential for human reproduction. A variety of immunological contraceptives - mainly for women but also for men - are now being tested in clinical trials. The `vaccine' which is most far advanced aims to neutralize the human pregnancy hormone hCG (human chorionic gonadotrophin), a hormone produced in a woman's body by a fertilized egg shortly after conception. This hormone is altered, then coupled to a bacterial or viral carrier (for example, a diphtheria or tetanus toxoid) so that the immune system mistakes the natural pregnancy hormone

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* Latin American, Caribbean, African, Asian and Pacific countries

for an infectious germ and reacts against it. The body thus does not get a signal to prepare for pregnancy and the

fertilized egg is expelled. Other immunological contraceptives are developed to interfere with the production of sperm, the maturation of egg cells, the fertilization process, or the implantation and development of the early embryo.

We oppose the development of immunological contraceptives. Our main reasons are:

1. ABUSE POTENTIAL

Immunological contraceptives will not give women greater control over their fertility, but rather less. Immunological contraceptives have a higher abuse potential than any existing method. They will be long-acting (depending on the type they may last from one year to life-long). They cannot be `switched off' and they are easy to administer on a mass scale because they will be injectables or a single pill. Researchers claim that the popularity and wide-spread acceptance of anti-disease vaccines could facilitate the introduction of antifertility `vaccines', especially in LACAAP countries. This compounds our concern about mass administration of immunological contraceptives without people's knowledge or informed consent.

2. MANIPULATION OF THE IMMUNE SYSTEM FOR CONTRACEPTIVE PURPOSES

Immunological contraceptives present no advantage for women over existing contraceptives. Because they use the immune system, they are inherently unreliable. Individuals can react completely differently to the same kind of immunological contraceptive. For example, the Indian anti-hcg formula, the most advanced method, did not work for 20% of the women; while its effect lasted from six months to over two years in other women. In addition, stress, malnutrition and disease will cause unpredictable failures of the contraceptive. In women and men with a predisposition to allergies and auto-immune diseases, on the other hand, the `vaccine' may cause life-long sterility. People will have no outward sign to know whether and when an immunological contraceptive is working.

Immunological contraceptives are unlikely to ever be harmless. They interfere with delicate and complex immunological and reproductive processes. There are many potential risks: induction of autoimmune diseases and allergies, exacerbation of infectious diseases and immune disturbances, a high risk of fetal exposure to ongoing immune reactions. As research on antifertility `vaccines' began 20 years ago, little or no thought has been given on how immunological contraceptives may directly or indirectly increase risks of HIV infection, or hasten the onset of full-blown AIDS.

Interference with the immune system for contraceptive purposes is indefensible at a time when primary health care systems in many countries are being dismantled, when the incidence of many infectious diseases are increasing, and when we have become acutely aware of the preciousness and complexity of our immune defense. *

3. UNETHICAL CLINICAL TRIALS

Clinical trials have taken place in India, Brazil, Sweden, Finland, Dominican Republic, Chile, Australia. Trials are currently taking place in India (perhaps also in the United States) and are planned in Sweden.

International standards of ethics in clinical trials state that human experimentation should only take place if the product being developed offers advantages over existing options. Immunological contraceptives offer no advantage in terms of efficacy, reversibility, safety, protection against sexually transmitted diseases or control by the user. The risks to women and men cannot be justified.

In addition, these trials are of concern because:

* There has been insufficient testing of the anti-HCG contraceptive on animals before testing in humans; the animals used do not give enough indication of adverse effects for women and their children;
* The enrollment of women was not based on informed consent. The efficacy and safety of the immunological contraceptive has been overstated. Consent forms have compared immunological contraceptives to anti-disease vaccines. This analogy obscures the differences in principle of action and purpose between the manipulation of the immune system for contraception and the induction of immune defense against harmful micro organisms;
* There has been insufficient data collection about adverse effects to women and to children born to women during trials.

4. FRAMEWORK OF CONTRACEPTIVE RESEARCH

The interplay between population control institutions, Northern and Southern countries, religious institutions, the medical establishment, as well as the community, the society and male partners profoundly influences the type of contraceptives available and the way they are being provided - or not provided. As many researchers readily admit, the concept of anti fertility `vaccines' was conceived in a "demographic driven, science led" framework. The major funders of contraceptive research want to increase the effectiveness of population control programmes. Most of the scientists involved in the research see the body as a machine to be mastered. The major trend in contraceptive development has been to create technologies which are long acting, have a low user failure rate, which lend themselves for mass fertility control - and which interfere with delicate and complex processes in the human body. Research on intrauterine devices, long-acting hormonal injectables and implants (Norplant) has been given precedence over user

controlled low-tech methods such as diaphragms and condoms, or over existing local practices of fertility control. Women are seen as better contraceptive acceptors than men. Most contraceptive research is still directed at methods for women.

Antifertility `vaccines' are a logical culmination of this framework.

WHAT DO WE WANT

We call for a radical reorientation of contraceptive research. Population control should not be placed above the interests of women as individuals. Approximately 10% of public funding for new contraceptive research worldwide is currently being spent on antifertility `vaccines'. We would like to see this funding redirected. The aim must be to enable people - particularly women - to exert greater control over their fertility without sacrifying their integrity, health and well being. Contraceptive development must be oriented at the realities of women's lives. Above all it must consider local health care conditions and the position of women in society.

We call on all research institutions involved, in particular the National Institute of Immunology. The Population Council and the World Health Organization to immediately stop all research on immunological contraceptives.

We call on all funders to stop financing this type of contraceptive research.

DRUGS CONTROLLER "APPROVES" DEPO PROVERA
(Interviews with Drugs Controller on 11.4.94)

By Rukmani Anand & C. Sathyamal

Injectable contraceptives like Depo Provera and Net-en are back in the news. And this time it could be your gynaecologist who prescribes it for you, and your local chemist who dispenses it. So how useful are these hormonal injections, and how safe?

Depo Provera and Net-en have been around for the last twenty five years. Depo Provera (depo medrosyprogesterone acetate) and Net-en (norethisterone enanthate) are injections given three-monthly or two-monthly to prevent pregnancy.

They contain a synthetic hormone which is similar to progesterone, a naturally occurring female hormone.

They produce a series of changes in the higher brain centres (hypothalamus and pituitary glands), the ovaries, and the inner lining of the uterus (endomentrium) resulting in a contraceptive effect.

Both drugs have serious side-effects, which are given separately in a box.

Both the products have been dogged by controversy. Multinationals Upjohn in the U.S. and Schering in Germany have found it extremely difficult to get approval in their own countries.

When approval was finally given to Schering by the Federal Health Office in Germany in 1983 it was qualified by the label "second rate". The actual quote from the Press & Information section of the national health authority Fed. Rep of Germany reads: "Their (injectables') use can only be justified in rare cases; the products are clearly second rate".

Meanwhile, in the U.S. right through the seventies and eighties the debate over approval by the powerful Food and Drugs Administration (FDA) continued unabated. It was not until 1992 that the FDA finally approved Depo Provera for use as a contraceptive.

Field testing of both Net-en and Depo Provera has been going on in India since the seventies. Thousands of women have been exposed to Net-en and Depo Provera as part of the Indian Government's clinical trials. However in 1975 Depo Provera trials were discontinued (See Box)

Net-en trials, however, continued right through till phase IV. And in 1986/87 the Drugs Controller of India gave his approval for the marketing of Net-en through German Remedies the Indian subsidiary of Schering. But Schering has been unable to enter

the market with Net-en because of stiff opposition by women's groups.

These groups have not only actively campaigned against Net-en, they have also filed a Supreme Court case against the Drugs Controller of India, ICMR, The Ministry of Health, and the State of Andhra Pradesh (where trials had been going on).

Health hazards to women and the clear absence of informed consent by women who were made to use these injectables as part of the Government's clinical trials formed the basis ofthis public interest litigation filed by Stree Shakti Sangathana, Saheli, Chingari and others.

The case is still pending a hearing in the Supreme Court. The Drugs Controller of India has yet to file his reply to the several charges levelled against him in court.

So, in the 1990's what exactly has changed?

The Government has ushered in a new liberalisatin policy opening up access to Indian markets, throwing all caution and controls to the winds.

"Today's policy says any doctor can import any drug", says Dr. Das Gupta, The Drugs Controller of India. He added: "Whether you like it or not, the policy has been made. I am not here to question policy, which comes from above."

But the Drugs Controller of India is meant to play a key role in safeguarding the health interests of the Indian population, and in particular of women.

In the new political climate clinical trials are being replaced by post marketing surveillance. In other words the new buzz-word is "acceptability" rather than "safety" which was the major concern of clinical trials.

According to Dr. Das Gupta: "In the contraceptive field clinical trials do not give much information. It is a tunnel vision. Post marketing surveillance is what will give the necessary information".

Said Dr. Das Gupta; "I have cleared this contraceptive Depo Provera on relative safety and efficacy (It can never be 100 per cent safe). But I am not convinced about acceptability, because of the socio-economic pattern. It is like Cadbury's or Nestle's chocolate. Until it is put in the market who can say which will be more acceptable?"

Special "informed consent" forms are to be signed by any woman who starts taking Depo Provera from her doctor. This has been made mandatory by the Drugs Controller.

The real question, however is: Why should the woman have to sign a consent form if the drug is safe?

Or should we suspect that clinical trials are being carried out in the guise of post marketing surveillance? And that Indian women are still the guinea pigs? The only difference now being that middle class women will be given this dubious privilege; the role of guinea pigs having earlier been reserved for women from the poorer sections.

In response to such apprehensions, Dr. Das Gupta said: "The controversy created by women's groups is childish. They say copper-Ts are good, oral contraceptives not good, injectables not good. This is like saying`sari' is good, `kurta' is not good. *`Women ko murga banaa diya, yeh kya baat hai!"*

Why has the Government introduced these drugs into the private market rather than the family planning program?

"Private marketing will have much fewer women who will be exposed. The women will be paying for the contraceptive and therefore will check and re-check. And moreover there will be supervision of the women by the company", explained Dr.Das Gupta.

Dr. Das Gupta appears to have accepted the swing in international opinion asserting the safety of the injectable. The most significant turnaround has been by the FDA in the United States which in 1992 gave it seal of approval to Depo as a contraceptive.

To what extent the FDA approval was influenced by the population control lobby in the US is a different question, which we need not go into over here.

What has in fact not changed is, that to date, no Indian study carried out has concluded that either of the injectables are a safe contraceptive with acceptable side effects.

In any case, the Family Planning Programme will have to wait at least two years before Depo Provera can be used within its framework said Dr. Das Gupta. "I have not allowed the drug to be put in the Family Planning Programme, because a large number of women will be exposed. And I have asked the ICMR to do a pre-programme-introducation study, which means Phase IV clinical trials", said Dr Das Gupta.

ICMR, however, is hemming and hawing about their role in further Depo provera trials. Dr Badrinath Saxena, Dy Director Genral at ICMR when asked whether they had initiated any phase IV studies with Depo said: " I don't know, we are doing so many studies. Why don't you ask the Drugs controller. We are purely an advisory body".

The injectables are being touted as a spacing method. This means that when a woman decides to stop using them, her body systems get back to normal, and she is able to conceive.

The information packet provided by UpJohn and Max Pharma (which is the Indian company marketing Depo Provera) gives pregnancy rate figures which on the face of it sound reassuring. However, for each individual woman who wants to have ababy it is not percentages that count, but a simple question: what are the chances of my not getting pregnant?

In this context, the latest edition of a standard text book,(Goodman & Gilman's `The Pharmacologogical Basis of Therapeutics',1991) available to all medical students says: "Depo Provera (medroxyprogesterone).. should be used only if the possibility of permanent infertility is acceptable to the patient".

Interesting corroboration for the restricted usage of Depo was available at the height of the controversy in the U.S. when the Select Committee on Population was told by a representative of Grady Memorial Hospital" It (Depo) is recommended for post-partum women unable to schedule a sterilization for several months, for women over 30, or mentally retarded women..." (and other such categories).

In 1987 despite the existent ban on Depo for contraceptive use, it was nonetheless used by the Americal Health Services on their indigenous American Indian population as well as on the mentally retarded women inside institutions.

In France too, Depo was mainly reserved "for immigrants with poor language skills and mentally impaired women judged incapable of managing their own contraception".

It does not require too much logic to figure out that in making Depo provera "available" to third world women, the hidden inference is -- that we similarly are incapable of making informed choices and so require a "second-choice" provider-controlled technology to reduce our fetility rates.

Another key question that needs to be focused upon is : if any Indian woman suffers upon taking this injectable, who will compensate her?

In the U.S. the whole question of legal liability of drug companies, of doctors, of gynaecologists, exercises a great many minds and costs the company millions of dollars in out-of-court settlements and insurance coverage. But in India, nobody seems liable. .

Company representatives of Upjohn and Max Pharma when contacted did not seem unduly concerned about product liability in India.

The Drugs Controller of India, expansively stated that he was not legally liable for complications arising out of <u>any</u> drug" use since, "there is no drug which doest not have any adverse drug reactions (ADR) associated with it".

However, Dr Das Gupta did have this to say: "Although I have no legal liability, I have taken on "conscience" liability. My responsibility is to see to the packet insert that goes into the package. You see, I am not an advocate of injectables but the time has come when we have to give the choice to women".

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